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the wisconsin medical journal

ANNUAL "BLUE BOOK" ISSUE

PRESENTED EACH YEAR SINCE 1924

Articles relative to medicolegal, socio-economic matters of direct concern to the physician.
Membership roster, services and structure of the State Medical Society of Wisconsin.

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STATE MEDICAL SOCIETY OF WISCONSIN
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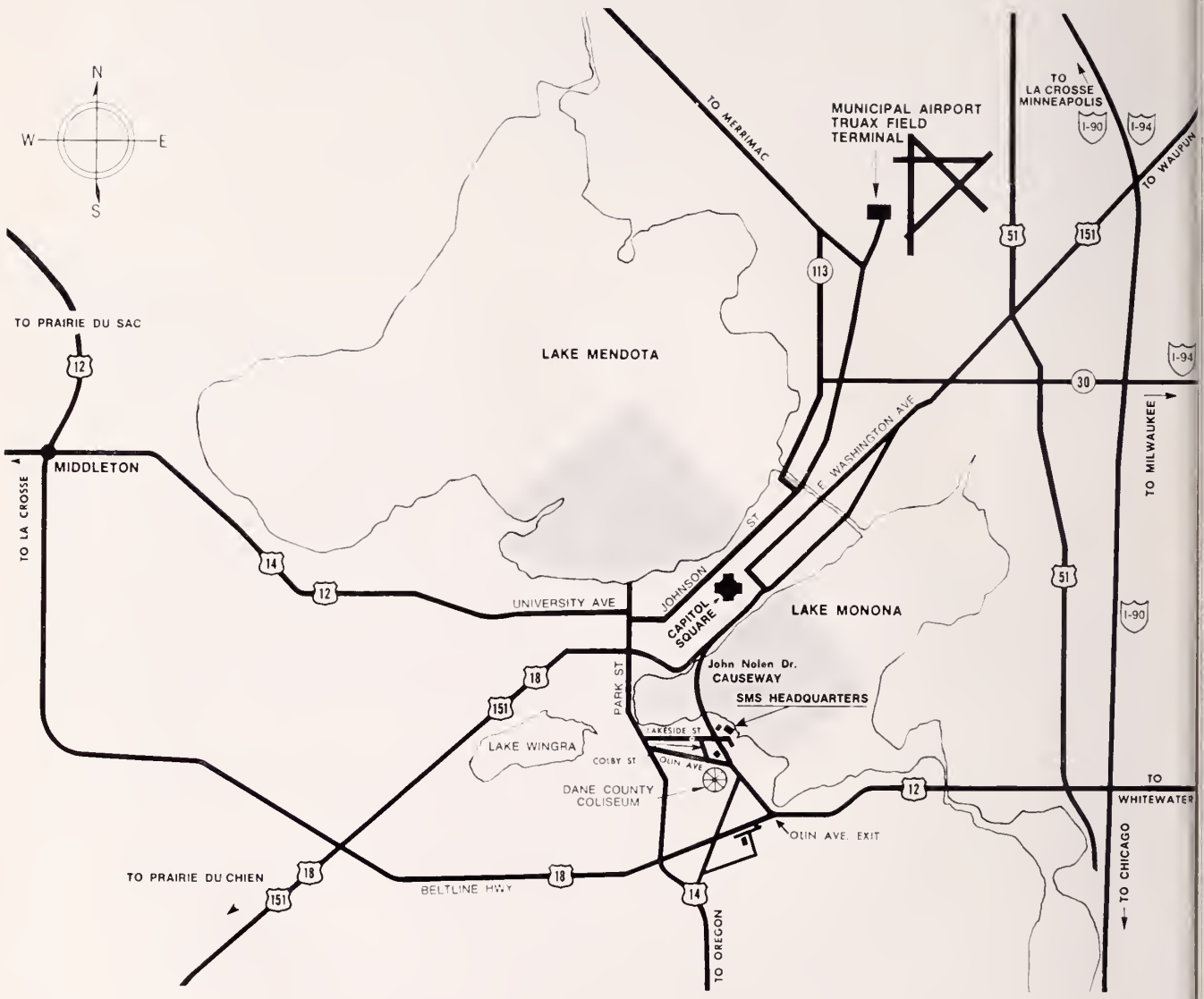
official publication of
THE STATE MEDICAL SOCIETY OF WISCONSIN

JANUARY 1969



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The headquarters "home" for over 4,000 Wisconsin physicians

Offices are open from 8:15 a.m. to 4:35 p.m., Monday through Friday. Telephone number: area code 608/257–6781. Parking is reserved for visitors in the two rows nearest the building.

Guides are available for tours of the building which contains many interesting and valuable collections of medical memorabilia, historical artifacts, and educational exhibits.

A trip to the Society "home" in 1969 will be a rewarding experience.

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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WISCONSIN MEDICAL JOURNAL
VOL. 68, NO. 1 JANUARY 1969

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Governor Orders "Freeze" to Offset Huge Deficit in Medical–Public Assistance Costs

In his first major act of 1969, Governor Warren P. Knowles ordered a "freeze" on salary increases, promotions, new state hiring, and out-of-state travel.

Gov. Knowles said the action was necessary to offset the effects of a $25.9 million deficit stemming from "unanticipated increased costs" for medical assistance and public assistance programs. The Governor's announcement was accompanied by a letter from Wilbur J. Schmidt, Secretary of Health and Social Services, which said the deficit was "the result of increased numbers of recipients as well as the continually rising average cost per case."

"The increases of recent months have completely defied the trends of the past and have left us with higher than expected caseloads and costs," Schmidt said.

Schmidt said that his current forecasts indicate deficits in public assistance of $9.9 million, in medical assistance of $9.7 million, and in county hospital aids of $6.3 million. In public assistance, Schmidt said "the greatest pressure has been in the program of Aid to Families with Dependent Children (AFDC), principally as a result of widened eligibility for such benefits."

Schmidt said that "we have been taking some steps to slow down the pace of program increases in medical assistance."

"There may be other steps that will need to be invoked," declared Schmidt. "However, since the law stipulates that payments to the providers of service in medical assistance are to be based upon the 'usual and customary' fees, and since the 'free choice' provision also exists, it may be necessary, if more stringent measures for control are to be taken, to obtain legislative changes."

In another letter reported by the Governor, Wayne F. McGown, Secretary of the State Department of Administration, said the Department of Health and Social Services should be asked to implement immediately "any administrative actions which can serve to reduce and check the fast increasing medical costs we are experiencing in the medical assistance programs."

President James Urges New Ideas in Physician Shortage

PRESIDENT JAMES REPLIES

Governor Knowles issued his "freeze" order on Friday morning, January 3. The same afternoon, the President of the State Medical Society of Wisconsin, Dr. W. D. James, Oconomowoc, sent a letter to Governor Knowles expressing the Society's concern, calling for another State Medical Society-sponsored conference on health care costs, and explaining that physician expenditures constitute only eight cents of each Medicaid dollar.

See page 15 for complete text of Doctor James letter.

The President of the State Medical Society, Dr. W. D. James, Oconomowoc, called upon medical and legislative leadership to "produce new ideas, remodel old concepts, and devise some thoroughly innovative efforts" to ease the physician shortage in Wisconsin.

In opening the conference, Dr. James reported the national shortage of "something like 52,000 physicians." He said, "I've been told that the U.S. government alone currently has job openings for the entire year's output of the nation's medical schools."

Commenting on the Wisconsin problem, he said:

(Continued on page 17)

Shortage of Physicians Conference Draws 150

VIEWPOINTS, PROPOSALS TO RECEIVE ATTENTION

How does Wisconsin get more physicians? There were almost as many ideas as participants when the State Medical Society held its "Conference on Proposals to Ease the Shortage of Physicians in Wisconsin."

The meeting, at Society headquarters in Madison Dec. 14, drew nearly 150 physicians, legislators, medical educators, and others.

There were ideas by the dozen. For example: Cut the training time, look for men who like hunting or fishing, give the new doctor a tax break such as that provided to industry, or subsidize medical schools with a sweepstakes.

Another idea, advanced with considerable seriousness, recognized the feminine angle of physician recruitment: "Find a way to appeal to the doctor's wife, and you'll find a doctor."

The conference, in itself, didn't solve the physician shortage in Wisconsin. No one expected it to do so.

But it did produce a great deal of earnest discussion of the problem and a good many ideas on what might be done in the future to relieve the shortage of medical manpower in the state.

This wealth of ideas was enumerated by Dr. E. J. Nordby, Madison, chairman of the medical society's Council, as he concluded the conference with a "Summary of Proposals for Action."

The following ideas were among many advanced by the conference participants:

1. Change admission requirements at both Wisconsin medical schools:
   a. To permit the admission of more freshmen medical students each year.
   b. To place less emphasis on grade-point average as a key factor in admission.
2. Arrange to provide deferments from military service for those physicians who agree to practice a specific number of years in an area of special physician shortage in Wisconsin. All physicians are now subjected to at least two years' service upon completion of their internships.
3. Expand the facilities of both Wisconsin medical schools in accord with the recommendations of the Governor's Task Force on Medical Education (160 freshmen medical students each year in each school). Several conference participants suggested that each school be expanded to at least 300 freshman places.
4. In addition to enlarging the classes of medical students, expand the facilities of the medical schools, not only to produce more MDs but also to prepare paramedical personnel as well.
5. Change the curriculum at each medical school to:
   a. Reduce the time required for an MD degree from its present eight or nine years to six or seven years.
   b. Alter the content to place less emphasis on specialization.
6. Develop more and better audio-visual aids to provide the medical student with greater exposure to medical care situations which he would not usually observe while in medical school.
7. Expand audio-visual aids for continued postgraduate education of the practicing physicians.
8. Expand audio-visual methods as an aid to the practice of medicine—for example, one medical clinic has a cardiologist who maintains a closed circuit television monitoring system for heart patients connecting the patient in the hospital with both his office and his home so that he may directly observe patient reaction wherever he is.
9. Develop programs of training "physician assistants" to increase physician productivity both in the hospital and in the office.
10. Expand financial assistance:
    a. With loans and scholarships to those currently in school.
    b. Special help, especially non-refundable grants, to persons just leaving high school and during their higher education. This would be especially helpful to "disadvantaged" persons who currently have difficulty completing even the premedical years. This would also involve special educational help to make up for the alleged gap in scholastic ability among those who have come from some of the state's "poorer" quality secondary schools.
    c. To help doctors locate in remote areas of Wisconsin. The argument is made that in some areas a physician can not make a reasonable living only from the proceeds of private practice and that some state financial assistance in return for public health services may be necessary.
    d. Tax incentives to lure physicians in Wisconsin just as they are granted to industry.
    e. A public relations-communications program to attract out-of-state physicians to Wisconsin and to convince graduates of

(Continued on page 16)

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EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

Office of the President

WILLIAM D. JAMES, M.D.

340 Summit Ave. • Oconomowoc, Wisconsin 53066

STATE MEDICAL SOCIETY OF WISCONSIN

January 3, 1969

The Honorable Warren P. Knowles
Governor of Wisconsin
Madison, Wisconsin

Dear Governor:

The State Medical Society of Wisconsin shares your concern with rising public welfare expenditures, especially as these involve health care. This is consistent with our training and responsibility in the totality of health care for the individual.

To this end, our Society, last November 16, hosted a statewide conference on health care costs. It was attended by nearly 50 representatives of state government agencies, health care providers and the business, labor and "consumer" community. In light of your action, I am asking that this conference be reconvened promptly so that the full knowledge and energies of this group can be directed toward any immediate remedies available to Wisconsin.

Further, I understand that Title XIX (Medicaid) expenditures in Wisconsin totaled $115,000,000 for the fiscal year ending June 30, 1968. As citizens and taxpayers, physicians are interested in so large an expenditure, although I note that only about $9 million of this went for physicians' services. This is less than eight cents of each Medicaid dollar.

Nonetheless, let me assure you, the members of the Wisconsin Legislature and appropriate department heads, that the State Medical Society stands ready to offer every cooperation and assistance in reviewing Wisconsin's health care program under public welfare. We must seek the utmost economy while, at the same time, assuring needed and quality health care for all, including the less fortunate in our midst.

Sincerely,

W. D. James M.D.

W. D. James, M.D.
President

Congressman Concurs in Local Direction

Direction and control of public health in America should "be at the local level" with the medical profession itself "leading the way," declared Sixth District Congressman William E. Steiger (R–Oshkosh), at the State Medical Society conference on the shortage of physicians.

"It is a lot to ask of you that in your spare time you begin planning for health care in the U.S. in the years to come," Congressman Steiger told the physicians in his audience.

"But, if enough villages like Adell (Pop. 398, Sheboygan County) are without medical care, it soon becomes a major crisis, and if no plans or programs are developed by private individuals or groups, cries for government action will be loud and strong," the Congressman pointed out.

"Medical care is something no political party can ignore if the people of the nation complain," he said. "You, the doctor, should be in the forefront of those attempting to solve public health-care problems."

Congressman Steiger presented a series of suggestions to help relieve the physician shortage:

1. Devise plans to make more efficient use of present health personnel in the state.

2. Revise state and federal laws to help eliminate paperwork, legal entanglements, and barriers to better use of existing personnel.

3. Reevaluate admission requirements for medical school. "Are we prejudging medical students' ability to complete their education prior to entrance too severely?," he asked.

4. Begin medical education earlier —immediately upon graduation from high school, instead of waiting for the completion of four years of liberal arts education.

5. Greater training and use of paramedical personnel.

Especially appealing to Congressman Steiger was the idea of a "regional medical center" to serve rural areas.

"Medical care and facilities will not only keep and possibly attract citizens in small towns and rural areas," he said, "but hopefully will attract doctors as well."

"If these centers are combined with medical–educational institutions, and if facilities are such that internships can be taken there, then perhaps an MD can be induced to stay and practice in the area," the Congressman concluded.

Congressman William E. Steiger

SHORTAGE OF PHYSICIANS CONFERENCE *(Continued from page 14)*

Wisconsin medical schools to stay in Wisconsin. The State Medical Society is beginning this program with an "MDs Like It Here" project.

11. Expand and increase the usefulness of the State Medical Society's Placement Service which seeks to assist communities looking for physicians. It was suggested that closer liaison between the medical schools and the Placement Service would be helpful.
12. The Legislature should consider:
    a. Changing the licensing requirement for foreign-trained physicians. The chief point of contention is the requirement for citizenship.
    b. Revision of liability statutes so as to provide greater incentive for physicians to utilize non-MD assistants and to clarify the role of the paramedical person in the treatment of the sick.
    c. The levy of more taxes for expanded health manpower facilities.
13. Improve internship programs to attract more medical students into taking internships in Wisconsin.
14. Improve the residency programs so as to attract more physicians to take their specialty training in Wisconsin. Reports from many sources indicate that a high percentage of physicians tend to practice in the same state in which they take their residency training.
15. Find more physicians' wives who want to live in Wisconsin. Many who attended the conference made reference to the role of the doctor's wife in deciding where they will live and he will practice.
16. Emphasize the attributes of Wisconsin for those interested in the outdoors—hunting, fishing, water sports, skiing and the like. Many physicians have strong interests in these areas.
17. Seek to provide different levels of medical education to produce different types of practitioners—for example, train one type of practitioner who would not do surgery or other specialized procedures. These are sometimes called mini-physicians.
18. Provide for earlier specialization training to decrease the total amount of time spent in formal education.
19. Organize health care on an areawide basis, with progressive care, personnel and facilities, much like the military uses in going from the corpsman to the field hospital to the general hospital. This might involve the use of helicopters to cover long distances in short periods of time.
20. Encourage the development of more group practice clinics serving wider areas.
21. Designate "diagnostic physicians" and "treating physicians."
22. Increase the productivity of present-day physicians. Reduce paperwork, increase efficiency, etc. through the application of better business methods to their office and treatment operations.
23. Integrate social workers, public health nurses, psychologists, and others into the active medical practice under direction of the MD. The goal would be to relieve the physician to spend his time with the more complicated cases, assist in decreasing hospitalization and increase the output of services in total. Included in this area is the need to develop housekeeping services, the lack of which often means that the older or disabled person does not wish to go home from a hospital or extended care facility.

These proposals, and others, will receive continuing attention from the State Medical Society and other interested groups.

Dr. Edwards Urges Third Medical School

FINANCIAL SUPPORT TO MARQUETTE URGENT

A strong appeal for state legislative assistance in relieving the shortage of physicians in Wisconsin was made by Dr. Richard W. Edwards, Richland Center, in addressing the State Medical Society conference in December.

Doctor Edwards is a general practitioner and a member of the House of Delegates of both the State Medical Society and the Wisconsin Academy of General Practice.

"Only if the legislators of the state show an active interest in the problems of medicine in Wisconsin today, can there be the hope of financial assistance and the legislative changes necessary to reverse this trend in Wisconsin," Dr. Edwards declared.

"The most burning issue," according to Dr. Edwards, "is state financial backing to Marquette School of Medicine."

"It is ludicrous to consider the possibility of this school closing. It would be foolish for legislators to waste time bickering over who should sit on the governing board. The problem is financial and it is immediate," Dr. Edwards declared.

Second priority, said Dr. Edwards, goes to establishment of a third medical school in the state. He urged that the new school be "founded on the basis of family practice."

Richard W. Edwards, MD

Dr. Edwards called upon the State Legislature to create a massive financial assistance program for medical students. Voluntary efforts, including those of the State Medical Society's Charitable, Educational and Scientific Foundation loan fund which currently has $176,000 on loan to medical students, are "but a drop in the bucket," he argued.

He called for immediate creation of a state "incentive loan fund" for young physicians with no repayment required if the doctors practice for up to five years in Wisconsin communities needing their services.

Dr. Edwards also called for the creation of family practice departments in the state's two medical schools. Arguing that family practice is the "only branch of medicine to which a medical student is not adequately exposed," Dr. Edwards said "significant changes must take place in education and attitude so that every patient can have a meaningful doctor–patient relationship with at least one real physician."

The Richland Center doctor also called upon the Legislature to become more interested in separating the research and teaching functions of the UW medical school.

"I feel very strongly that there should be a complete divorcing of the research and teaching functions in a medical school," Dr. Edwards declared. "In spending taxpayers' money, I feel the medical school staff should be paid by salary alone. I understand that research must continue, but very often good researchers do not make good teachers."

Doctor Edwards cited statistics to show that specialization is increasing and family practice is decreasing.

In 1949, he said, 37.9% of Wisconsin's practicing physicians were in specialty practice. In 1966, this had risen to 67.5%.

Another "disturbing statistic" he said, is that 46% of the state's general practitioners are over 55 years of age, compared to only 27% of all doctors.

William D. James, MD

URGES NEW IDEAS

(Continued from page 13)

"Here in Wisconsin we have 112 patient-care physicians per 100,000 population as of Dec. 31, 1967. The U.S. rate as a whole is 132. Some of our neighbor states are better off than we: Minnesota—136, Illinois—125, Michigan—131.

"But some are worse off, too: Indiana—94 and Iowa—105.

"Two counties in Wisconsin have no resident physicians at all, Florence and Menominee, but most of their residents are within 25 miles of a doctor or hospital."

Dr. James indicated that "as far back as 1868, this Medical Society has urged the State Legislature to expand medical school facilities at the University of Wisconsin."

"This has been accomplished, even though slowly, over the years," said Dr. James. He recalled that in 1951 and 1953, the Society worked with legislative committees studying the problem. At that time, the Society had suggested, but the Legislature did not accept, the idea of "one- or two-year subsidies" to doctors who would set up practice where they were especially needed.

Dr. James pointed out that currently the State Medical Society has taken the position that "the immediate expansion of both schools (Wisconsin and Marquette) is the quickest, most economical, most effective way to secure more physicians for Wisconsin."

Recruiting Responsibility Up to Doctors

DUCKWORTH WANTS LOCAL DIRECTION

Now is the time for doctors to "see the big picture" and assume the responsibility for recruiting other doctors, according to T. A. Duckworth, senior vice-president and secretary of Employers Insurance of Wausau.

Duckworth addressed the Dec. 14 Medical Society conference on the shortage of physicians. He spoke as a "consumer" and chairman of both the advisory council of Comprehensive Health Planning in Wisconsin and the advisory council of the Wisconsin Regional Medical Program.

He expressed concern that comprehensive health planning and regional medical programing "be influential in supplying physicians where the public thinks they are needed."

He said, "It is to our advantage to keep the government in the role of the paymaster and leave the operation and management of the programs up to local administration."

Duckworth called for serious inquiry into such questions as:

1. Why did our present crop of physicians locate in Wisconsin?

2. Can our two medical schools make more places available right now? Can they compensate for admission attrition by admitting 130 students and perhaps graduating 110 instead of 100?

3. If it is a fact that medical school policy requires a certain grade-point average to be accepted, is there any possibility of a modification in these rules?

4. A "startling" number of communities, a total of 130, say they would "like to have a doctor." How can these communities help themselves?

5. Can and will the medical schools encourage more of their seniors to seek internships in Wisconsin hospitals?

6. What about expanding the residency programs to include rural hospitals for part of the specialty training?

7. Is there really no hope for getting physicians to practice in the smaller communities in Wisconsin?

Duckworth suggested that a good deal of the problem with regard to physician shortage in Wisconsin is a sales job.

"We must recognize that one of the most important sales is selling the physician's wife," he argued. "She certainly must be sold on a small community, and other doctor's wives can probably do the best job of selling."

"I feel that we should spend some more money and effort in establishing more and better residency training programs in Wisconsin with the hope of attracting physicians who are interested in getting out and taking care of people," he continued.

Duckworth also inquired as to whether "the public really desires specialization in medicine" or are medical educators and present specialists "encouraging it from the standpoint of more money and more free time?"

He also urged consideration to having others on the health team relieve the MD of some responsibilities, reduce the period of MD preparation by streamlining premedical requirements, and changing the "character" of the individuals being accepted into medical school.

Medical Society Launches Six-Point Program to Ease "Doctor Drain"

The State Medical Society of Wisconsin will launch a six-point program to help ease the "doctor drain" in the state, it was reported by Dr. W. D. James, Oconomowoc, Society president.

The new campaign will be entitled "MDs Like it Here," and will involve "both personal and professional commitments by Wisconsin physicians," said Dr. James.

The six-point program is as follows:

1. All Wisconsin doctors and their wives will be asked to wear a lapel pin to express "our confidence in Wisconsin as a good place to live and to practice medicine," continued Dr. James.

The black and gold pin is similar to one worn by Governor Warren P. Knowles, and will bear the legend, "MDs Like it Here."

2. The Society will prepare brochures appraising Wisconsin's assets as a place to live and practice medicine, and will distribute the literature nationwide to medical students.

3. The Society will develop a "communications campaign" to convince students in Wisconsin's two medical schools to remain here after obtaining their degrees.

4. The Society will urge "immediate expansion of the University of Wisconsin medical school and the Marquette School of Medicine as the quickest, most economical, most effective way to secure more physicians for Wisconsin."

The Society suggestion is that both schools be expanded to handle 160 students each per year, instead of the current 107. This would mean an increase of about 50%. It is similar to a recommendation made by the Governor's Task Force on Medical Education a short time ago.

5. The Society will "intensify" its "Careers in Health" program, which is aimed at Wisconsin high school students.

6. The Society will also step up its efforts to obtain more funds for medical student loans. Currently the Society has more than $176,000 out on such loans. The loan program is administered by the Society's Charitable, Educational and Scientific Foundation.

Dr. James said, "I personally believe that the scientific, economic, and social climate in Wisconsin is challenging and satisfying. We plan to say so to the entire medical world!"

Young People Are Turned Off by Medicine, Medical Student Says

Faced with a "difficult and urgent" physician shortage, many of the participants at the State Medical Society conference on the problem presented their personal ideas on what could be done about it.

Everyone among the 150 attendees had his say.

And almost everyone had an idea or two for solving the physician shortage.

In a fervent appeal for expansion of the state's two medical schools and the creation of a third, Bertram N. McNamara, Milwaukee, a member of the Governor's Task Force on Medical Education, urged that "we start now on all three tasks."

"I feel that the richest nation in the world can well afford this kind of expenditure," he said. "It doesn't do any good to be a citizen of the richest nation if we are not here to enjoy it."

George Murphy, MD

Dr. George Murphy, La Crosse, contended that the presence in Wisconsin of health quackery was a "block to physicians coming here." He urged legislation to "outlaw chiropractic" as the first step.

Mike McDermott, Milwaukee, a junior medical student at Marquette, claimed that "young people are turned off by medicine today." He said young doctors don't come to Wisconsin because they want to go where "things are happening—where they are part of the community in the total sense."

Roger Hamilton, Madison, representing the Wisconsin Hospital Association, urged doctors to learn to increase their own productivity with better business and treatment procedures. He said that a 5% increase in the productivity of all doctors would have the effect of producing 14,000 new doctors.

Doctors Air Pros and Cons of GP Status

Is the general practitioner on the way out? Is our health care system based on the family practice physician? Can we restore a balance between specialists and family doctors?

The future of the "family doctor" and the "specialists" occupied the attention of many who attended the State Medical Society's conference on proposals to ease the shortage of physicians.

Dr. Dale V. Moen, Shell Lake, made an eloquent appeal for the training of more "primary physicians." "The public wants family doctors," he declared.

"It isn't necessary to have 3 or 4 doctors see each patient in a hospital. Most people don't need all the tests every time they see a physician or go to the hospital," Dr. Moen argued.

"The family physician should direct the care, choosing specialist attention when it's needed," he said. "The biggest problem is that people don't know who to call when they are sick."

Dr. Marc F. Hansen, Madison, reported that he is heading an experimental "primary care" program at the University of Wisconsin Medical School. Its purpose is to train more doctors who are qualified to help the great majority of patients.

Dr. Hansen believes that his new program will produce more "family-care" physicians by giving medical students more exposure to family practice. He thinks they now see too much of highly specialized teachers practicing in narrow fields.

His thinking appears to be borne out in statistics cited by Dr. Gerald Derus, Madison, president of the Wisconsin Academy of General Practice: "70% of freshman medical students indicate they want to practice general medicine, but by the time they are seniors, the number drops to 20%."

Contrary thinking was expressed by Dr. Ben Lawton, Marshfield, "The GP is dead, let him be. Since 80% of the graduates want to specialize, let's make use of them," he contended. "Organize them into groups, and quit trying to make them over."

Dr. E. J. Nordby, Madison, suggested that the "GP is not dead, he's just changed his name—many internists and surgeons do a great deal of general practice."

UW REGENT WANTS 6-YEAR CURRICULUM

Dr. James Nellen, Green Bay, a University of Wisconsin regent, expressed pessimism that a third medical school would become a reality in the near future.

He said the cost of transferring the University of Wisconsin medical school to a new location would put a damper on expenditures for a new school. In addition, he felt the relocation of the school in Madison would be at least two years in coming.

Dr. Nellen called for immediate action to "compress the medical curriculum into a total of six years." This could be done, he said, by having two years of pre-med, then four years of medical school, including the internship.

"This would not only pick up two classes of students, but it would add two years to the practicing life of every physician," he declared.

Dean Eichman Offers "Way Out"

A campaign to emphasize the positive was proposed by Dr. Peter Eichman, Madison, dean of the University of Wisconsin Medical School, as one way to get more physicians in the state.

Wisconsin should emphasize the superior quality of its hospitals and medical care, he said. "The level of medicine in Wisconsin is above the national average."

Dr. Eichman pointed to a possible "way out" with several questions:

1. "Why don't we take advantage of the fact that every graduate is deeply in debt. Wisconsin has a high tax structure, thus repayment of interest is a tax advantage. Perhaps we should grant other tax inducements to get a physician to stay here."
2. "Let's take advantage of federal monies available to us. We may find a reciprocal interest that comes to us."
3. "Why not take advantage of the peculiar educational gap in the health field by allowing progression from one degree of training to another for physicians, nurses, and others?"
4. Why not train a "new person on the health team—someone between a nurse and a doctor who could take over some of a doctor's tasks?"

Dr. Eichman also urged acceptance of the "actively concerned and eagerly willing" medical student of today who wants to participate earlier in health care.

State Senator Urges New Approach to Medical Training

State Senator Martin J. Schreiber (D–Milwaukee) has called for a partnership of government and the medical profession to effect solutions to the problem of the shortage of physicians in Wisconsin.

Speaking before the Conference on Proposals to Ease the Shortage of Physicians in Wisconsin sponsored by the State Medical Society at its headquarters in Madison, Schreiber said that the physician shortage is one of the most critical problems facing the state and it will become more acute unless we are willing to think of bold new approaches to the problem and to act on them.

Senator Martin J. Schreiber

Schreiber suggested that the state might consider a system of loans to medical students that would not have to be repaid, if upon graduation, a doctor decided to practice medicine in the state for a prescribed length of time.

"One of the big problems with young physicians is that they do not want to set up practice in rural areas because the technical facilities in rural hospitals are not adequate for the development of their medical and surgical skills and along with that they are miles away from the major hospitals that provide the facilities and the training they require. We must improve the number and quality of these facilities and make them readily available to rural doctors," said Schreiber.

"It may well be that one of the reasons why many young doctors spurn the practice of medicine in small communities is because they are overtrained for the type of practice they would develop there. If we could offer the alternative of a shorter period of medical training we might encourage these doctors to locate in areas that do not involve hospital-oriented or major surgical practices."

Schreiber strongly endorsed proposals for state aid to the Marquette medical school as a major step in easing the physician shortage in Wisconsin.

Marquette Dean Defends Current School Practices

An appeal for relief from "back-breaking deficits" was made by Dr. G. A. Kerrigan, Milwaukee, dean of Marquette School of Medicine.

"We are fighting to stay afloat and alive at Marquette," the dean declared. He appealed for state aid to the private school and indicated that Marquette's future is tied with the proposed Southeast Wisconsin Medical Center.

Dr. Kerrigan estimated it would take Marquette at least four or five years to increase its class size from 107 to 160 because of a current lack of space, and lack of funds to correct the problem.

Dr. Kerrigan said Marquette "accepts the challenge" to increase the size of its starting class, changes in curriculum, production of corollary health personnel, and integration with an academic medical center using both private and public institutions.

The dean challenged those who contend that admission standards are "too damn high." He argued that excellence is needed in those who render health care.

"Students with good grade-point averages are just as well endowed with concern for their neighbors as those who perform less well," he said.

Research cannot feasibly be separated from teaching in a medical school, Dr. Kerrigan declared. "We can't really learn all there is to know about medicine, we can only learn how to think about health problems."

He disagreed with the suggestion that Wisconsin utilize more foreign physicians, noting that the nation already recruits nearly 1,500 foreign doctors a year to maintain present physician-population ratios. "It's a sad commentary that we, the richest nation in the world, take these people from their countries where they are so badly needed," said Dr. Kerrigan.

W. D. James, M.D.

PRESIDENT'S PAGE

Medical Man Power Shortage

WHILE MOST SECTIONS of the United States suffer from a shortage of medical man power, we are told that the number of physicians in Wisconsin is at least 20 less per 100,000 population than the national average. We are told also that the number of newly trained doctors leaving Wisconsin each year exceeds by at least 19 those applying for license to practice here.

The State Medical Society recently sponsored a conference of practicing physicians, medical educators, state legislators, and interested citizens, to consider proposals that might help to alleviate this acute and critical shortage of doctors.

It was agreed that our two medical schools must be enlarged to graduate at least 360 seniors each year. Loan funds must be increased so that fewer students find it necessary to drop out because of financial problems. It was suggested also that there may be a need for changes in the medical curriculum and a reduction in the number of years needed to complete a medical education.

Wisconsin needs more approved intern and residency programs to attract students from schools outside the state. These programs are an important source of physician recruitment.

Possibly the method of delivery of medical care needs to be changed. Perhaps it would be more efficient to service several small communities by a group of physicians practicing together. This would enable them to have time off for postgraduate training and for family and recreational activities knowing that their patients were receiving adequate care during their absence.

The possibility of increasing the efficiency in each doctor's office was suggested. This might enable him to see a greater number of patients per day without severely increasing the time and effort expended.

With a realistic approach, the army and other government services could well reduce the number of physicians they draw from civilian practice.

To compound this already serious shortage of medical man power in our state comes the announcement that the number of nursing home beds in the Milwaukee metropolitan area will double in the next two years. This will increase the need for physician care and will require the services of 10,000 additional paramedical personnel, including at least 1,000 registered nurses. What is happening in Milwaukee will undoubtedly be duplicated in many other areas of the state.

Since the physician shortage affects every Wisconsin community and every Wisconsin doctor, it behooves us to work together toward a solution of our mutual problem.

Let us hear your ideas on how to induce more physicians to "Like It Here."

W. D. James M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Corpulent Profit

IT IS PERHAPS CHARACTERISTIC of the affluent society that obesity has become a general and serious medical problem. In most of the world and throughout most of history nutritional deficiencies have plagued mankind. The search for food has provided the dynamic for the establishment of civilizations and for the formation of our culture. Now when men—or at least that portion of them who have the good fortune to live in the United States—have at last succeeded in producing a reasonably good life for a majority of the people, the problem has switched: we are now confronted with the hazard of over-partaking in what we have been struggling to assure, namely, a sufficiency of food.

Obesity is no joke, least of all to the victim of it. The image of the jolly fat person is a sad one. He is usually unhappy because he eats too much, and eats too much because he is unhappy. His life is shortened unless the illness is treated properly, and he is miserable with the knowledge that he is literally digging his grave with his teeth.

Medical science has long been aware of the problem, and many people have been helped by competent physicians. Other sufferers have fallen into the hands of cultists, hypnotists, or crooked physicians.

The treatment of obesity is a complex, serious medical problem that must be studied and treated individually. Usually, treatment is a slow process, often involving a continuous struggle to readjust to a sensible pattern of eating and exercise. Taking off pounds is difficult, tedious, and frustrating. No wonder that many sensitive, less-than-iron-willed people succumb to those who promise quick, simple, effortless weight reduction. Recently, as the AMA has already observed, a few physicians have limited their practice to the treatment of obesity, and some of those physicians are neither ethical nor competent in their therapy. Newspapers have reported the vast profits to be made by the exclusive treatment of obesity, and the hard light of publicity has again suggested to the uninformed that the medical profession is capitalizing on the woes of the sick.

Physicians who customarily employ potent drugs to combat obesity often do so for no other reason than to obtain quick, easy results and sure-fire profits. There is no excuse for the employment of such drugs as digitalis, diuretics and thyroid, especially in combination, unless they are specially

indicated by endocrine or cardiac considerations. The use of inert "gland extracts," even for psychological assistance, is equally difficult to justify. Local medical societies should be alert to the danger the "fat doctor" poses not only to his own patients but also to the medical profession. Awareness of the problem and the courage to take responsible action against an offending colleague should control the problem before scandal occurs.

On the other hand, ethical physicians should be prepared to appreciate the problem of the obese patient. The diagnosis of the malady's root is a challenging one, capable of evoking the most critical perception and evaluation of human values.

The treatment can never be casual or offhand. The simple advice: "stop eating," or "lose weight or else," is tragically ineffective. The physician must address himself to the patient's psyche as well as to his medical problems. The judicious use of anorexiants and sedatives have been found effective combined with a sensible diet and course of exercise; psychotherapy can be provided during regular office visits, with understanding emotional support.

In some localities lay organizations, such as TOPS (Take Off Pounds Sensibly) have helped many overweight people, both to reduce their weight and to keep it down. These legitimate organizations should be encouraged and patients should be urged to participate in their activities when appropriate.

Treatment of the obese requires consummate skill to be successful. The effort is worth while because it will improve the patient's health and will keep him out of the clutches of the "fat doctor."—D.N.G.

Dollars Today—
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AMA-ERF

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was founded in 1954 to permit physicians and friends of medicine an opportunity to sponsor projects affecting the health of Wisconsin citizens.

Among the many projects which are supported by this method is the Medical Student Loan Fund. Since the integration of the loan fund into the Foundation in 1955, the student loan aspects of the program have grown.

Every practicing physician recognizes the unquestionable need for timely aid to the kin of his profession who face unusual financial hardship. Personal hardship strikes at physicians and their families as well as others. Through the Foundation there is an opportunity for professional persons to assist their colleagues who suffer adversity.

The Scientific medicine activities of the Foundation include circuit teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

The voluntary contributions recommended by the House of Delegates is being supplemented by many physicians and others who find in the Foundation an opportunity for special gifts. Gifts may take a number of forms such as cash, life insurance, securities, books, old medical instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary in their wills. Gifts may be unrestricted, permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor. In any event, all contributions to the Foundation are deductible for income tax purposes.

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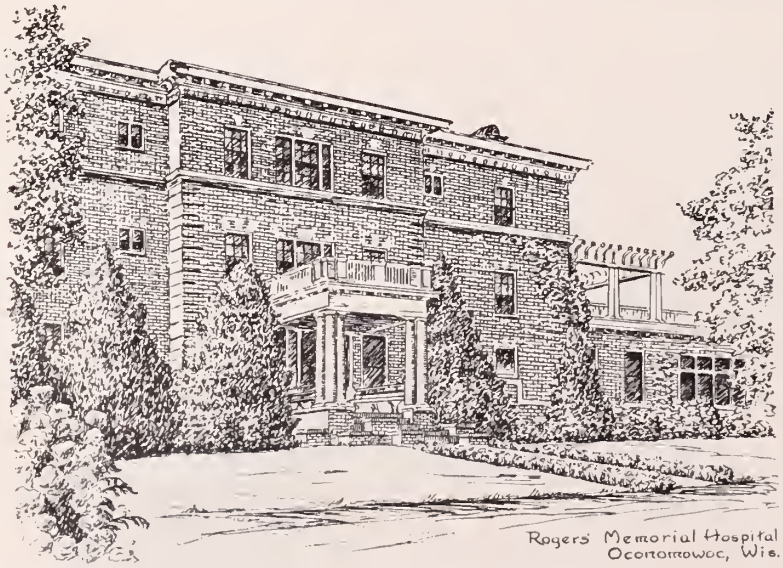

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SECTION

OPHTHALMOLOGY

JANUARY 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTEO BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

PROPOSED WISCONSIN SCHOOL EYE SAFETY LAW

The Wisconsin Society for the Prevention of Blindness had the "School Eye Safety Law" introduced to the state legislative Committee on Public Welfare Apr. 18, 1967. It became Senate Bill 329 and was passed by the Senate in 1967. Senate Bill 329 was read once in the Assembly and tabled. This very worthwhile bill was never reread; therefore, it "died."

As a result of this action, the Industrial and School Eye Safety Committee of the Wisconsin Society for the Prevention of Blindness was completely reorganized and expanded to reach the "grass roots" level throughout the state.

The Industrial and School Eye Safety Committee has continued to grow. Twenty-seven of the 50 states have passed the School Eye Safety Law. The Society plans to have this bill reintroduced in the Senate and Assembly simultaneously in 1969.

According to the Statistics Division of the National Society for the Prevention of Blindness, 4,100 eye injuries occurred in 1968 to Wisconsin students and teachers in schools, colleges, and universities. The economic loss is obvious.

The Wisconsin Society for the Prevention of Blindness is again asking the members of the State Medical Society of Wisconsin to support the passage of the "School Eye Safety Law" in 1969.

The bill will be introduced in the 1969 legislature in the following form:

AN ACT to create 146.016 of the statutes, relating to safety glasses.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

146.016 of the statutes is created to read:

146.016 Eye Protective Devices. (1) Every student and teacher in schools, colleges and universities participating in any of the following courses:

(a) Vocational or industrial arts shops or laboratories involving experience with:

1. Hot molten metals;
2. Milling, sawing, turning, shaping, cutting, grinding or stamping of any solid materials;
3. Heat treatment, tempering or kiln firing of any metal or other materials;
4. Gas or electric arc welding;
5. Repair or servicing of any vehicle;
6. Caustic or explosive materials;

(b) Chemical or combined chemical-physical laboratories involving caustic or explosive chemicals or hot liquids or solids; is required to wear industrial quality eye protective devices at all times while participating in such courses or laboratories.

(c) Such devices may be furnished for all students and teachers or purchased and sold at cost to students and teachers, and shall be furnished for all visitors to such classrooms and laboratories.

(d) "Industrial quality eye protective devices" as used in this section, means devices meeting standards of the USA standard safety code for head, eye and respiratory protection, Z2.1–1959 approved by the USA Standards Institute, Inc., and subsequent revisions of such code, provided that such revisions are approved and adopted by the industrial commission. To assist in its evaluation of the subsequent revisions of the said code, there is created an advisory committee on eye protective devices. Members to be appointed by the industrial commission.

(e) The industrial commission shall insure compliance with this section.

Prepared by VINCENT POLLINA, Chairman, Industrial and School Eye Safety Committee, Wisconsin Society for the Prevention of Blindness, 312 East Wisconsin Ave., Milwaukee, Wis. 53202.

VISION SCREENING BOOKLET

The Wisconsin Department of Health and Social Services has published a booklet entitled "The Eye and Vision Screening in the Preschool and School Years." Copies have been mailed to all Wisconsin ophthalmologists. This booklet is valuable to ophthalmologists when nonmedical people call upon them for advice on this subject.

The booklet was prepared by Dr. George Sparks of Marshfield when he was a U.S. Public Health Service consultant to the Wisconsin State Department of Health and Social Services.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

Dr. Richard Schultz will address the Milwaukee Ophthalmological Society Feb. 25 at the University Club in Milwaukee. His topic will be "External Eye Diseases."

VOLUNTARY DUES ASSESSMENT

The Executive Committee would like to remind all ophthalmologists that voluntary dues for the year 1969 are still being received. The regular membership contribution is $100.

Checks are payable to: Section on Ophthalmology. Mail to: State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Geigy

MEDICAL MEETINGS

POSTGRADUATE COURSES

1969 WISCONSIN

Feb. 11–13: Annual Telemark Ski Symposium, Wisconsin Academy of General Practice, Mt. Telemark, Cable.

Feb. 19: "In-depth" teaching program—Respiratory Therapy, University of Wisconsin Medical School and State Medical Society of Wisconsin, Madison.

Mar. 6: Senior Medical School Day of Senior Medical School Week, State Medical Society of Wisconsin, Madison.

Mar. 13: "In-depth" teaching program—Female Hormones at Age Fifty, University of Wisconsin Medical School and State Medical Society of Wisconsin, Madison.

Mar. 13–14: Conference on a Clinical Approach to Coronary Artery Disease, University of Wisconsin Medical Center and University Extension, Madison.

Mar. 26–27: Fourth Annual Spring Conference on the Prevention and Management of Sports Injuries, Wisconsin Center, Madison.

Mar. 27–29: Conference on Primary Pediatrics and the Processes of Child Health Care, Department of Pediatrics, University of Wisconsin Medical Center and Department of Postgraduate Medicine, University of Wisconsin Extension, at Wisconsin Center, Madison.

May 1: Jackson Clinic–Marquette School of Medicine postgraduate teaching program, Madison.

May 7: Projected Clinics, Wisconsin State Dental Society.

May 12–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 15: Annual Meeting, Wisconsin Surgical Society, in conjunction with the Annual Meeting of the State Medical Society of Wisconsin, Milwaukee.

Spring: Conference on Pesticides and Insecticides, Committee on Occupational Health of State Medical Society of Wisconsin.

Spring: Town–Gown Symposium, State Medical Society of Wisconsin.

Sept. 11–14: Annual Meeting, Wisconsin Society of Internal Medicine, Deer Park Lodge, Land O'Lakes.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton–Schroeder Hotel, Milwaukee.

1969 NEIGHBORING STATES

Feb. 6–11: 65th Annual Congress on Medical Education, Council on Medical Education of the American Medical Association, Palmer House, Chicago.

Apr. 11–13: Annual meeting, National Association of Blue Shield Plans, Chicago, Ill.

Apr. 14–25: Postgraduate course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago.

April 20–25: 50th Annual Session, American College of Physicians, Conrad Hilton Hotel, Chicago, Ill.

Apr. 24–26: 31st Annual Session, American Academy of Physical Medicine and Rehabilitation, Sheraton–Chicago Hotel, Chicago.

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

June 10–13: Annual convention, Catholic Hospital Association, Minneapolis, Minn.

Oct. 25–26: North Central Medical Conference, St. Paul Hilton, St. Paul, Minn.

1969 OTHERS

Feb.: ACP postgraduate course—Gastroenterology, Louisiana State University, New Orleans.

Feb. 3–5: Sectional meeting, American College of Surgeons, featuring general surgery, urology, orthopedics, Fontanelle Hotel, Omaha, Neb.

Feb. 8: Second Annual Symposium on the Medical Aspects of Sports, Committee on the Medical Aspects of Sports of the Medical Society of the State of New York, Americana Hotel, New York City.

Feb. 8–13: Annual Congress and Teaching Seminar, International Academy of Proctology, Hollywood Beach Hotel and Country Club, Hollywood, Fla.

Feb. 17–20: Surgery of the Hand, University of Colorado School of Medicine, Denver, Colo.

Feb. 17–21: ACP postgraduate course—The Patient and His Family, University of Cincinnati College of Medicine, Cincinnati, Ohio.

Feb. 21–22: Postgraduate continuation course in Gastroenterology, Institute of Gastroenterology, Good Samaritan Hospital, and VA Hospital, Del Webb TowneHouse, Phoenix, Ariz.

Feb. 24–26: Sectional meeting, American College of Surgeons, featuring gynecology-obstetrics, neurosurgery, general surgery, and symposium on trauma, Brown Hotel, Louisville, Ky.

Mar. 3–7: Symposium on Arthritis and Related Disorders, New York University Medical Center, New York City.

Mar. 10–12: Joint meeting for doctors and nurses, American College of Surgeons, featuring general surgery and eight surgical specialties, Sheraton–Boston Hotel, Boston, Mass.

Mar. 10–13: Annual meeting, New Orleans Graduate Medical Assembly, The Roosevelt Hotel, New Orleans, La.

Mar. 13–15: Course in Current Problems in Electroencephalography: Advances Toward Their Solution, American Electroencephalographic Society and Baylor University College of Medicine, Houston, Tex.

Mar. 17–19: 25th Anniversary Meeting, American Academy of Allergy, Americana Hotel, Bal Harbour, Fla.

Mar. 24–28: ACP postgraduate course—Modern Pathology for the Internist, University of Pittsburgh, Pittsburgh, Pa.

Mar. 26–28: Three Days of Gastroenterology, American College of Physicians, Grady Memorial Hospital Auditorium, Atlanta, Ga.

Mar. 31–Apr. 2: Psychiatry and the Internist (20th symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Apr.: AHA Council on Clinical Cardiology—"Clinical Electrocardiography and Vectorcardiography," Augusta Ga.

Apr. 9–11: Management and Care of Respiratory Insufficiency, University of Colorado School of Medicine, Denver, Colo.

Apr. 18: Annual symposium on Infectious Diseases, American Academy of General Practice, Battenfield Auditorium, Kansas City, Kan.

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

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REFERENCES:

1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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MEDICAL MEETINGS *continued*

Apr. 21–25: 50th annual session, American College of Physicians, Chicago, Ill.

Apr. 28–May 1: Annual Clinical Meeting, American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Fla.

May 8–10: National Conference on Breast Cancer, American Cancer Society, Shoreham Hotel, Washington, D.C.

May 12–16: ACP postgraduate course—Internal Medicine, University of Pennsylvania School of Medicine (Pennsylvania Hospital), Philadelphia, Pa.

May 18–21: Annual Meeting, Pharmaceutical Manufacturers Association, The Greenbrier, White Sulphur Springs, W. Va.

June: AHA Council on Clinical Cardiology, title and location to be announced.

June 9–13: ACP postgraduate course—Neurology for the Internist, Bowman Gray School of Medicine, Winston-Salem, N.C.

June 16–19: ACP postgraduate course—Auscultation of the Heart, University of Oregon Medical School, Portland, Ore.

June 16–20: ACP postgraduate course—Hematology, University of Rochester School of Medicine, Rochester, N.Y.

July 7–11: Postgraduate Course—Clinical Electrocardiographic Interpretation, Hahnemann Medical College and Hospital, Philadelphia, Pa.

July 14–18: Postgraduate course—Interpretation of Cardiac Arrhythmias, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 11–17: Postgraduate course—Space Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1969 AMA

July 13–19: Annual meeting, American Medical Association, New York City.

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

May 11–14: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1970 OTHERS

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Telemark Ski Symposium

The Wisconsin Academy of General Practice will sponsor the annual Telemark Ski Symposium, Tuesday, Wednesday, and Thursday, Feb. 11–13, at Mt. Telemark, Cable, Wis.

The meeting offers six hours of AAGP prescribed credit. The scientific programs will be held in the ski lodge at the base of Mt. Telemark.

Faculty presenting the program are from the Mayo Clinic, Rochester, Minn.: Dr. Ronald L. Linscheid, assistant professor of orthopedic surgery; Dr. W. Mitchell Sams, assistant professor of dermatology; Dr. Robert C. Burton, consultant in neurology; and Dr. Donald C. McIlrath, assistant professor of surgery.

All physicians are invited to attend the meeting. Those attending are asked to secure their own motel reservations directly. A list of motels in the area can be obtained by writing to the Manager, Mt. Telemark Ski Area, Cable, Wis.

For more information concerning the ski symposium write to the Wisconsin Academy of General Practice, 2825 N. Mayfair Road, Milwaukee, Wis. 53222.

Coronary Artery Disease Course

The University of Wisconsin Medical Center and University Extension presents a Conference on A Clinical Approach to Coronary Artery Disease, Mar. 13–14, Madison.

The purpose of this course is to review coronary artery disease as it relates to clinical practice. The major emphasis is an attempt to correlate pathogenesis, pathology, and clinical presentation of coronary artery disease with the investigations and therapy. Close faculty/registrant contact and demonstrations of some newer tools of therapy are integral parts of the course.

Some of the featured speakers from the University of Wisconsin will be Dr. Edgar S. Gordon, professor of medicine; Dr. George G. Rowe, professor of medicine; Dr. Richard H. Wasserburger, professor of medicine; and Dr. William P. Young, professor of surgery.

For further information contact Dr. Thomas C. Meyer, Associate Dean, University of Wisconsin Medical School, 307 N. Charter Street, Madison, Wis. 53706.

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Oshkosh, Wis. 54901

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF NOVEMBER 20, 1968

NEW MEMBERS

Altman, S. David P., 606 West Wisconsin Ave., Milwaukee 53203
Aquino, Edmundo C., 145 North Main St., Monticello 53570
Bates, Donald E., 210 Madison Ave., Fort Atkinson 53538
Biehl, Mark D., 8844 Watertown Plank Rd., Milwaukee 53226
Brandt, Rosemary C., 8320 West Bluemound Rd., Milwaukee 53213
Cantwell, A. A., Jr., 117 East Green Bay St., Shawano 54166
Cassidy, George E., 17335 Patricia Lane, Brookfield 53005
Cossman, Francis P., 1300 University Ave., Madison 53706
Duchelle, Richard A., 5000 West Chambers St., Milwaukee 53210
Gold, Kenneth I., 1146 Grant St., Beloit 53511
Golding, Jacob L., 300 East Capitol Dr., Milwaukee 53212
Hauser, Gary C., 8844 Watertown Plank Rd., Milwaukee 53226
Job, Edward J., 2020 East Milwaukee, Janesville 53545
Kneubuhler, Hans, N82 W15401 Appleton Ave., Menomonee Falls 53051
Lamal, Andre H., 200 7th Avenue West, Ashland 54806
Langheim, Werner E., 2500 Overlook Terr., Madison 53705
Lucia, George E., Jr., 117 Ozark Trail, Madison 53705
Lyne, Benjamin W., 309 West Washington Ave., Madison 53703
Mathews, Richard J., 9205 West Center St., Milwaukee 53222
McCann, Michael L., 4410 Regent St., Madison 53705
Moss, Hubert V., Jr., 2712 Marshall Court, Madison 53705
Pitot, Henry C., 1300 University Ave., Madison 53706
Pulcini, John Dennis, 701 Copeland St., Madison 53711
Pulido, Ernesto D., Schiek Clinic, Rhinelander 54501
Riabov, S. N. 312 East 7th St., Superior 54880
Rubin, David K., 948 North 12th St., Milwaukee 53233
Uy, Mario L., 945 North 12th St., Milwaukee 53233
Webb, George E., Jr., 1300 University Ave., Madison 53706
Weber, David R., 693 East Division St., Fond du Lac 54935

CHANGES OF ADDRESS

Berger, J. V., Jr., 1025 Regent St., Madison 53715
Borstein, S. L., Oconomowoc, to P.O. Box 549, Hallandale, Fla. 33009
Breister, Karl A., 315 David Dr., Green Bay 54303
Brooks, Kenneth H., Kenosha, to 1251 N. 116th St., Wauwatosa 53226
Camacho, Ernesto M., Waupun, to 2727 Keystone Lane, Bowie, Md. 20715
Christian, James A., 1732 N. Prospect Ave., Milwaukee 53202
Cogan, Leo J., 2500 North Mayfair Rd., Milwaukee 53226
Cohen, Albert M., 7324 N. Seneca Rd., Milwaukee 53217
Coron, Alfred J., 1915 West Hampton Ave., Milwaukee 53209
Corser, David H., 815 South 10th, La Crosse 54601
Davis, F. A., 1025 Regent St., Madison 53715
Davis, F. J., 1025 Regent St., Madison 53715
Davis, M. D., 1025 Regent St., Madison 53715
Duehr, P. A., 1025 Regent St., Madison 53715
Ferwerda, James R., 8020 Sheridan Rd., Kenosha 53140
Foregger, Richard, 400 West Silver Spring Dr., Milwaukee 53217
Frank, Ralph C., 900 W. Clairmont, Eau Claire 54701
Frantz, J. A., Monroe, to 49 Circle Dr., Ft. Lupton, Colo. 80621
Franzen, Lyle D., Waukesha, to 1805 Hickory Hill Lane, Brookfield 53005
Gemmill, Worthy David, Serial #05541289, 10th General Dispensary, APO New York 09757
Gordon, John J., FPO New York, N.Y., to Naval Air Station, Lake Hurst, New Jersey 08733
Gundersen, G. A., Jr., 1836 South Ave., La Crosse 54601
Harkness, John W., Milwaukee, to 1228 Dale Drive, Silver Spring, Md. 20907
Henkle, Robert F., 549 W. Grand Ave., Port Washington 53074
Hoesley, Henry F., Shullsburg, to 121 Acewood Blvd., Madison 53714
Hofmeister, Frederick J., Milwaukee, to 10425 West North Ave., Wauwatosa 53226
Holzgrafe, Robert E., Waukesha, to 400 W. Silver Spring Dr., Milwaukee 53217
Hutson, C. F., 1025 Regent St., Madison 53715
Kenwood, Stanley N., 6150 W. Floral Lane, Milwaukee 53223
Kohler, Sidney H., 4527 West Center St., Milwaukee 53206
Lawrence, David L., 92 E. Division St., Fond du Lac 54935
Litton, Jason J., 11645 West Diane Dr., Milwaukee 53226
Locher, Roland A., La Crosse, to Rt. 1 N. Chipmunk Rd., Stoddard 54658
Longstreth, Charles R., 833 Sterling Dr., Fond du Lac 54935
MacMillan, David G., 1220 East Woodland, Barron 54812
Madsen, Renate E., 24 Fuller Dr., Madison 53704
Martens, William E., Milwaukee, to 10425 West North Ave., Wauwatosa 53226
Mitz, Morris, 609 East Lexington Blvd., Milwaukee 53217
O'Connor, Thomas A., 1021 East Spooner Rd., Milwaukee 53217
Orman, Edward S., Madison, to 3152 South 35th St., La Crosse 54601
Pugh, George J., Box 3694, Milwaukee 53217
Reik, Robert P., Milwaukee, to 10425 West North Ave., Wauwatosa 53226
Reslock, Conrad P., Waupun, to P. O. Box 61, Port Antonio, Jamaica, West Indies
Rettig, Frank E., Milwaukee, to 3685 Sunny Crest Dr., Brookfield 53005
Schmidt, Daniel K., 330 West Silver Spring Dr., Milwaukee 53217
Schumacher, John P., 211 South Monroe, Green Bay 54301
Schwartz, Walter R., Milwaukee, to 10425 West North Ave., Wauwatosa 53226

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SOCIETY RECORDS *continued*

Sepp, Ingeborg, 1545 South Layton Blvd., Milwaukee 53213
Sivertson, Sigurd E., La Crosse, 307 N. Charter St., Madison 53706
Spicuzza, Salvatore, Milwaukee, to 2312 Venre Ave., San Jose, Calif. 95124
Sturm, Rodney J., 1025 Regent St., Madison 53715
Sun, Kwoh Cheng, Siren, to Apt. A-1G 3020 Ridgecliff Dr., Flint, Mich. 48504
Thatcher, Donald S., 2130 West Hemlock Rd., Milwaukee 53209
Thomas, Griffith L., Prentice, 1765 Camino Dr., Forest Grove, Ore. 97116
Van Riper, Hart E., Yonkers, New York, to Geigy Pharmaceuticals, Ardsley, N. Y. 10502
Vogel, Heinz G., 2727 Marshall Ct., Madison 53703
Vondrak, Ben F., Milwaukee, to 10425 West North Ave., Wauwatosa 53226
Walker, Lynn J., 711 West Capitol Dr., Milwaukee 53206
Wallestad, P. W., R. 1, Box 786, Port Washington 53074
Wendt, William P., Elm Grove, to 10425 West North Ave., Wauwatosa 53226
Wesenberg, Richard L., Baltimore, Md., 1300 University Ave., Madison 53706
Zahl, Wesley H., South Milwaukee, to 361 E. Cypress Ave., Burbank, Calif. 91502
Zarbock, Floyd M., Mukwonago, to 111 Maple St., Big Bend 53103

REMOVED FROM MEMBERSHIP

Baumle, Clarence E., Green County, resigned
Brittin, Geoffrey M., Dane County
Eiseman, Theodore S., Waukesha County, transferred to Illinois
Grumke, E. N., Dane County
Kishpaug, Harold W., Rock County, resigned
Klatt, Kenneth M., Dane County, transferred to Illinois
Kloppedal, Erling A., Sauk County, transferred to Minnesota
Kundert, Fred W., Green County, resigned
Waun, James E., Dane County
Zimmermann, Timm A., Vernon County, transferred to Washington

DEATHS

Smith, Russell C., non-member, Sept. 8, 1968
Leighton, Frederick A., Sheboygan County, Oct. 15, 1968
Freitag, Samuel A., Rock County, Oct. 26, 1968
Gale, Joseph W., Dane County, Oct. 26, 1968
O'Hara, John J., Waukesha County, Nov. 5, 1968
Morton, Homer H., Iowa County, Nov. 11, 1968
Heifetz, Eugene C., Milwaukee County, Nov. 15, 1968

WISCONSIN LICENTIATES

The following physicians were granted licenses by oral examination by the Department of Regulation & Licensing Medical Examining Board at a meeting in Madison, January 9–10–11, 1968.

Name	*School of Graduation*	*Year*	*City*
Abels, Johannes	University of Groningon	1952	Madison
Ashraf, Hebatollah Seid	University of Tehran	1958	Oak Lawn, Ill.
Avestruz, Alex P.	University of Santo Tomas	1956	Spring Valley
Avestruz, Nerissa L.	University of Santo Tomas	1955	Spring Valley
Blyth, William	University of Glasgow	1934	Cherokee, Ia.
Brennan, John Thaddeus	University of Wisconsin	1967	Madison
Buchanan, Susanna F.	University of Wisconsin	1967	Madison
Capati, Ana Camaya	University of Santo Tomas	1959	Neillsville
Cesario, Thomas Charles	University of Wisconsin	1965	Overland Park, Kan.
Chun, Theresa W. C.	Seoul Women's Med. C.	1955	Pownal, Me.
Galang, Miguel T., Jr.	University of Santo Tomas	1955	Milwaukee
Gildersleeve, John W.	University of Wisconsin	1967	Grand Rapids, Mich.
Gonzalez, Ramon A.	Santo Domingo University	1951	Chicago, Ill.
Harbour, Jeanne D.	School of Med. Paris	1946	Madison
Ihle, Peter Mandelert	University of Wisconsin	1967	Eau Claire
Jaeger, John Gustave	University of Wisconsin	1967	Rochester, Minn.
Kass, David Joseph	University of Zurich	1964	Madison
Knutzen, David Bruce	University of Wisconsin	1966	Madison
Kranendonk, Donald Hugh	University of Wisconsin	1966	La Crosse
Larkin, Edwin Roland	University of Wisconsin	1962	Madison
Meier, Pierce James	University of Wisconsin	1967	Oakland, Calif.
Melby, Neal Arthur	University of Wisconsin	1965	New Richmond
Mellencamp, David Dixon	University of Wisconsin	1966	Rapid City, S. D.
Nishioka, Hiro	University of Manitoba	1954	Green Bay
Padwick, Michael John	University of Wisconsin	1967	Concord, Calif.
Paust, Joan Carol	University of Wisconsin	1967	Milwaukee
Pulido, Ernest D.	Far Eastern University	1957	Rhinelander
Ramirez, Guillermo	Nat. University of Columbia	1958	Madison
Shahidi, Nasrollah T.	University of Paris	1954	Madison
Smotkin, Lowell	University of Wisconsin	1967	Grand Rapids, Mich.
Stiehm, William D.	Columbia University	1964	Tenafly, N. J.
Tavera, Menandro, Jr.	University of Philippines	1961	Milwaukee
Taylor, Thomas Fleming	University of Wisconsin	1967	Milwaukee
Tilgner, Arthur Dewey	University of Colorado	1966	Rochester, Minn.
Uy, Mario L.	University of Santo Tomas	1956	Milwaukee

Name	*School of Graduation*	*Year*	*City*
Weinman, Mary Sue	University of Wisconsin	1967	Madison
Wood, Mary E. T.	University of Wisconsin	1967	Oregon
Zachman, Richard Dean	University of Florida	1966	Madison

The following physicians were granted licenses by oral and written examinations by the Department of Regulation & Licensing/Medical Examining Board at a meeting in Madison, January 10, 1968.

Name	*School of Graduation*	*Year*	*City*
Ackerman, R. Marshall	University of Pittsburgh	1962	Iowa City, Ia.
Angevine, James M.	University of Wisconsin	1959	Madison
Burke, Joseph L.	University of Illinois	1964	Chicago, Ill.
Chervenak, William A.	George Washington University	1955	St. Croix, Minn.
Clift, Warren D.	N. Y. Medical College	1962	Stoughton
Dwork, Ralph E.	Anderson College	1946	Harrisburg, Pa.
Erickson, Marc T.	University of Washington	1966	Milwaukee
Gottschalk, Paul G.	University of Illinois	1960	Marshfield
Hanley, James C.	University of Illinois	1965	Chicago, Ill.
Harned, Gerald L.	Cal. College of Med	1963	Milwaukee
Harris, Gilbert W.	University of Iowa	1966	Madison
Janes, Donald R.	University of Kansas	1960	Wausau
Janis, John F.	Marquette University	1959	La Crosse
Kelertas, Algimantas	University of Zurich	1963	Chicago, Ill.
Kirkhope, Thomas G.	Marquette University	1963	Milwaukee
Kropp, August D.	Marquette University	1964	Greenfield
Kuhn, John M.	Marquette University	1964	Brookfield
Luy, Jerome J., Jr.	Marquette University	1961	Menomonee Falls
Martin, David E., III	Yale University	1957	Wabasha, Minn.
Pansch, Donald J.	Northwestern University	1965	Neenah
Plzak, George J.	University of Chicago	1964	Madison
Poland, Maynard D.	Northwestern University	1961	Milwaukee
River, Louis P., III	Loyola University	1954	Oak Park, Ill.
Semmens, William J.	Northwestern University	1964	Minneapolis, Minn.
Shull, H. Dean, Jr.	Indiana University	1964	Milwaukee
Stalzer, Edward V.	University of Prague	1945	Chicago, Ill.
Stuart, Karl A.	Marquette University	1966	Milwaukee
Wessels, Dennis H.	University of Iowa	1963	Shawano
Wolf, Frank Lynn	University of Wisconsin	1964	Madison
Wu, Jane Pu Chu	Nat. Taiwan University	1958	Madison
Zeller, Hector C.	University Nacional de Mex.	1952	Hastings, Minn.

The following physicians were granted licenses by oral and written examinations by the Department of Regulation & Licensing/Medical Examining Board at a meeting in Madison, April 5, 1968.

Name	*School of Graduation*	*Year*	*City*
Babbitt, Lon David	University of Wisconsin	1961	Green Bay
Bender, Joseph P.	Ohio State University	1965	Chetek
Bennett, Paul, II	Northwestern University	1960	Beloit
Braun, James E.	Creighton University	1966	Milwaukee
Burrows, Thomas H.	Johns Hopkins University	1962	Menasha
Cain, Nancy Napier	Ohio State University	1967	Madison
Cain, Russell	Ohio State University	1967	Madison
Carter, Thomas Lynn	Western Reserve University	1963	Madison
Corson, John S.	University of Oregon	1964	Madison
Crowley, Leonard V.	University of Vermont	1949	Minneapolis, Minn.
Cunningham, Thomas	Loyola University	1953	Rochelle, Ill.
Douglas, Herbert J.	State University of Iowa	1957	Milwaukee
Ferrazzano, Gabriel	Marquette University	1938	Racine
Giordano, Wally	Marquette University	1956	Twin Lakes
Grundberg, Arnis	University of Iowa	1964	Iowa City, Ia.
Gulyn, Anna B.	Leopold Franzens University	1957	Wausau
Hallquist, Stone	Northwestern University	1963	Lompoc, Calif.
Handley, J. George	University of Illinois	1966	Madison
Henderson, Robert	University of Virginia	1967	Madison
Holder, Lynn W.	University of Illinois	1961	Manitowoc
Hoyer, L. J.	University of Minnesota	1933	Oshkosh
Janda, Rudolph	University of Chicago	1944	Hinsdale, Ill.
Jeckle, Milan A.	Marquette University	1964	Spokane, Wash.
Job, Edward John	Loyola University	1959	Janesville
Kalambaheti, Kitti	Siriraj Medical School	1957	Sparta
Krapohl, Andrew J.	University of Michigan	1959	Marinette
McFetridge, John	University of Alberta	1953	Glencoe, Ill.
McGregor, William R.	University of Iowa	1965	Baldwin
Miller, Gerald J.	Marquette University	1965	Richfield, Minn.
Moore, Clarence E.	University of Iowa	1964	Iowa City, Ia.
Myers, William O.	Northwestern University	1955	Marshfield

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WISCONSIN LICENTIATES *continued*

Name	*School of Graduation*	*Year*	*City*
O'Malley, Thomas	Loyola University	1961	Stevens Point
Ranheim, Phillip	University of Minnesota	1964	West St. Paul, Minn.
Richardson, Francis	University of Illinois	1950	Waukegan, Ill.
Russman, Burton A.	Northwestern University	1955	Chicago, Ill.
Ricketts, Harry M.	Tulane Medical	1947	Wood
Sheldon, Warner F.	McGill University	1937	Eau Claire
Somers, Lowell M.	University of California	1967	Flint, Mich.
Troup, Charles W.	Northwestern University	1963	Milwaukee
Walcott, George	Boston University	1962	Milwaukee

March 23, 1968 in Madison (Special Meeting)

Zerzavy, Frederick	University of Zagreb	1942	Baltimore, Md.

The following physicians were granted licenses by oral and written examinations by the Department of Regulation and Licensing/Medical Examining Board at a meeting in Milwaukee, July 9, 10, and 11, 1968.

Name	*School of Graduation*	*Year*	*City*
Angevine, C. Douglas	University of Wisconsin	1962	Watertown, Me.
Ansushinha, Chirawan K.	University of Medical Sciences	1958	Madison
Atamdede, Aysel	University of Istanbul	1951	Franklin
Cleary, Michael G.	University of Wisconsin	1967	Torrance, Calif.
D'Cunha, George F.	University of Karachi	1958	Milwaukee
Doslu, Feridun Ahmet	University of Istanbul	1956	Milwaukee
Drasin, George Fraim	University of Wisconsin	1967	Madison
Ek, Marit	University of Cape Town	1959	Madison
Estrada, Jesus I.	University of Santo Tomas	1952	St. Louis, Mo.
Fernandez, Pascual B.	Manila Central University	1954	Milwaukee
Fetter, Victoria	University of Bruxelles	1966	Milwaukee
Gani, Mukhtar Ali	King Edward Medical College	1957	Milwaukee
Grausz, John Paul	University of Sydney	1958	Brookfield
Hegedus, Stephen I.	University of Wisconsin	1966	Balboa Heights, C. Z.
Hogman, Elizabeth	University of Wisconsin	1967	Phoenix, Ariz.
Hunold, Edward A.	University of Wisconsin	1966	Madison
Kampschroer, Bernard	University of Wisconsin	1967	Milwaukee
Kurtz, Peter Harvey	University of Wisconsin	1966	Cheyenne, Wyo.
Kuwayama, Susumu P.	Hokkaido University	1959	Kansas City, Kans.
Lamont, Frederick J.	University of Wisconsin	1967	San Francisco, Calif.
Lederer, Robert Louis	University of Wisconsin	1967	Rochester, N. Y.
Lulloff, Rolf Stuart	University of Wisconsin	1967	Madison
Madland, Thomas William	University of Wisconsin	1967	Milwaukee
Maleki, Massoud	Tehran University	1965	Milwaukee
Marcus, Melvin Lenard	University of Wisconsin	1966	Bronx, N. Y.
Prodans, Michael Dan	Zagreb University	1958	LaGrange Park, Ill.
Rathert, Roger A.	University of Wisconsin	1966	San Rafael, Calif.
Reinold, Jack Kenneth	University of Wisconsin	1966	Fresno, Calif.
Rodriguez, Justo	University of Madrid	1957	Marshfield
Saed, Amir	University of Tehran	1958	Forest Park, Ill.
Salvador, Fernando E.	University of Santo Tomas	1958	Beloit
Scheinman, Jonathan	University of Illinois	1966	Madison
Simonson, Melvin J.	Northwestern University	1960	Maywood, Ill.
Sakarya, Ismet	Ankara University	1954	Marshfield
Siy, Lucio Co	University of Santo Tomas	1960	Milwaukee
Thomas, William Odell	University of Wisconsin	1967	Sun Prairie
Way, Anthony Biden	University of Pennsylvania	1967	Madison
Wedell, Eric James	University of Wisconsin	1967	Burlington, Vt.
Weinhold, Frank M.	University of Wisconsin	1966	Speedway, Ind.
Zarka, Koussay	University of Damascus	1958	Hazel Green
Zarwell, David H.	University of Wisconsin	1965	Madison
Myers, Beverly Ann	McGill University	1961	Milwaukee

The following physicians were granted licenses by written and oral examinations by the Department of Regulation and Licensing/Medical Examining Board at a meeting in Milwaukee, July 10, 1968.

Name	*School of Graduation*	*Year*	*City*
Ahlstrand, Richard A.	University of Nebraska	1967	Madison
Berman, Joel A.	Upstate Medical College	1967	Milwaukee
Bishop, John C.	Marquette University	1967	Racine
Burdette, Robert D.	Northwestern University	1962	Madison
Carlson, Robert D.	Temple University	1962	Marshfield
Castilla Ortiz, Hugo	University of San Marcos	1957	St. Paul, Minn.
Chelecki, Stefan	Royal University of Bologna	1937	Madison
Cirillo, Nicholas	Georgetown University	1965	Waukegan, Ill.
D'Elia, Rudolph	Chicago Medical College	1936	Hayward
Diego, Benito B.	Manila Central University	1954	La Crosse

Name	*School of Graduation*	*Year*	*City*
Duchelle, Richard	Georgetown University	1959	Milwaukee
Edwards, Donald	St. Louis University	1962	Neenah
Esehenbaum, Edward	University of Illinois	1965	Waukesha
Esswein, James Lee	University of Wisconsin	1965	Madison
Fabrie, Kenneth S.	Marquette University	1967	Milwaukee
Floyd, Charles P.	University of Miehigan	1958	Marshfield
Fowler, Curtis W.	University of Kansas	1962	Wauwatosa
Friedman, Jerry Eli	Illinois College of Medicine	1961	Milwaukee
Friedrich, Eric	Washington University	1967	Milwaukee
Gardner, Philip M.	Loyola University	1967	Middleton
Gee, William F.	University of Wiseonsin	1967	Milwaukee
Gerhardstein, Richard	St. Louis University	1962	Milwaukee
Gibbon, Stanley	Marquette University	1966	Milwaukee
Gold, Kenneth Ira	State University of New York	1961	Beloit
Goldberg, Herbert	Medical College of South Carolina	1967	Milwaukee
Golding, Jacob	Arkansas University	1961	Milwaukee
Gotway, Clement A.	University of Illinois	1953	Milwaukee
Gray, Dorothy Lois	University of Texas	1961	Milwaukee
Greisehar, Robert L.	Marquette University	1967	Oshkosh
Hamaker, James B.	Johns Hopkins	1967	Milwaukee
Hammond, Charles	University of Illinois	1968	Neenah
Hansen, Peter T.	Marquette University	1967	Wauwatosa
Harrington, Gregory	Marquette University	1967	Milwaukee
Haskell, David S.	Marquette University	1967	Milwaukee
Haushalter, Robert	Marquette University	1967	Wauwatosa
Hemmy, David C.	Hahnemann Medical College	1967	Wauwatosa
Herman, La Vern Harry	University of Wisconsin	1956	Waukesha
Hirschler, Charles	University of Iowa (State)	1960	Madison
Hisgen, William J.	University of Wisconsin	1967	Madison
Holder, John Charles	University of Tennessee	1964	Minneapolis, Minn.
Horowitz, Ronald N.	University of Illinois	1965	Chicago, Ill.
Huebner, Robert	Northwestern University	1967	Milwaukee
Hutchens, Howard C.	University of Wiseonsin	1967	La Crosse
Imray, Thomas John	Marquette University	1965	St. Paul, Minn.
Itskovitz, Harold D.	University of Pennsylvania	1957	Milwaukee
Jacobs, Jamie Jay	University of Vermont	1965	Madison
Jaeobsohn, Harold A.	Marquette University	1967	Shorewood
Johnson, Charles J.	University of Wisconsin	1959	Madison

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Name	*School of Graduation*	*Year*	*City*
Johnson, Roger Paul	Marquette University	1967	Milwaukee
Kaehny, William D.	Marquette University	1965	Wauwatosa
Kenney, James M.	Marquette University	1967	Milwaukee
Koehn, Gerard G.	Marquette University	1967	West Bend
Komorowski, Richard	Marquette University	1967	Milwaukee
Lass, Thomas Erwin	Marquette University	1967	Milwaukee
Libnoch, Joseph A.	University of Illinois	1958	Milwaukee
Logan, Michael J.	Marquette University	1964	Madison
Mack, Robert Francis	Minnesota Medical College	1963	Marshfield
Martin, David Alfred	University of Missouri	1967	Madison
McClelland, George B.	Marquette University	1967	Milwaukee
McLean, Wallace W., Jr.	Marquette University	1967	Milwaukee
Meli, Robert Joseph	Marquette University	1967	Oshkosh
Miller, Donald A.	University of Illinois	1961	Gillett
Moayad, Cyrus P.	University of Geneva	1957	Cleveland, Ohio
Moore, Donald Earl	Case Western Reserve	1967	Milwaukee
Mundschau, Gerald A.	University of Wisconsin	1965	Sharon
Olen, Douglas W.	Marquette University	1961	Cudahy
Pesarillo, Servando	Manila Central University	1959	Arcadia
Pierpont, David B.	University of Wisconsin	1964	Chetek
Pierrot, Alan Hay	Stanford Medical College	1966	Wright Patterson AFB, Ohio
Pinn, Christopher	University of Illinois	1967	Aurora, Colo.
Post, Lawrence A.	George Washington University	1948	Milwaukee
Rikkers, Henry	University of Arkansas	1959	Middleton
Rozum, Leo Thomas	Marquette University	1967	Milwaukee
Sargeant, James G.	Marquette University	1967	Mayville
Savaglio, Vincent P.	Marquette University	1967	Milwaukee
Schleifer, Philip	Marquette University	1967	Boulder Junction
Schoofs, Greg G.	Northwestern University	1965	Medford
Schwindt, Charles	Ohio State University	1964	Madison
Seidel, Barry John	Marquette University	1967	Milwaukee
Sherman, Joel Avery	University of Chicago	1967	Madison
Stegman, Samuel J.	Indiana University	1965	Madison
Stripling, Burnell	New York Medical College	1960	Marinette
Stupek, Warren	National University of Ireland	1962	Fennimore
Tennant, Edward E.	University of Wisconsin	1948	Sterling, Colo.
Tsuchiya, Goro	Keio University	1953	Racine
Turner, James W.	State University of Iowa	1965	Iowa City, Iowa
Van Roy, Ronald L.	Creighton Medical College	1967	Madison
Vieira, Joaquim	Coimbra University	1956	Milwaukee
Wagner, Philip C.	Marquette University	1967	Milwaukee
Walsh, Denis E.	Marquette University	1967	Baraboo
Winemiller, Robert	University of Chicago	1961	Marshfield
Wolfe, Steven F.	University of Wisconsin	1967	Madison
Yahr, James Hull	University of Wisconsin	1967	Madison

Special written examination given July 25, 1968 in Milwaukee.

Name	*School of Graduation*	*Year*	*City*
Silverman, Donald	St. Louis University	1963	Chesterfield, Mo.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1969 WISCONSIN

Mar. 6: Senior Medical School Day of Senior Medical School Week, State Medical Society of Wisconsin, Madison.

Mar. 13: "In-depth" teaching program—Female Hormones at Age Fifty, University of Wisconsin Medical School and State Medical Society of Wisconsin, Madison.

Mar. 13–14: Conference on a Clinical Approach to Coronary Artery Disease, University of Wisconsin Medical Center and University Extension, Madison.

Mar. 26–27: Fourth Annual Spring Conference on the Prevention and Management of Sports Injuries, Wisconsin Center, Madison.

Mar. 27–29: Conference on Primary Pediatrics and the Processes of Child Health Care, Department of Pediatrics, University of Wisconsin Medical Center and Department of Postgraduate Medicine, University of Wisconsin Extension, at Wisconsin Center, Madison.

May 1: Jackson Clinic–Marquette School of Medicine postgraduate teaching program, Madison.

May 5–7: Annual session, Wisconsin State Dental Society, Milwaukee Auditorium, Milwaukee.

May 7: Projected Clinics, Wisconsin State Dental Society.

May 12–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 14–16: Annual Conference, National Society for the Prevention of Blindness, Pfister Hotel, Milwaukee.

May 15: Annual Meeting, Wisconsin Surgical Society, in conjunction with the Annual Meeting of the State Medical Society of Wisconsin, Milwaukee.

Spring: Conference on Pesticides and Insecticides, Committee on Occupational Health of State Medical Society of Wisconsin.

Spring: Town–Gown Symposium, State Medical Society of Wisconsin.

June 5–7: Conference on "The New Hospital Psychiatry," sponsored by the University of Wisconsin Department of Postgraduate Medicine, Department of Psychiatry, and the Wisconsin Psychiatric Institute of the University of Wisconsin Medical Center, Madison.

June 9: UW graduation day.

Aug. 2–3: State Medical Society Council meeting.

Sept. 11–14: Annual Meeting, Wisconsin Society of Internal Medicine, Deer Park Lodge, Land O'Lakes.

October: Wisconsin Work Week of Health, State Medical Society, Madison.

Oct. 8–9: Annual meeting, Wisconsin Academy of General Practice, Holiday Inn No. 2, Madison.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton–Schroeder Hotel, Milwaukee.

1969 NEIGHBORING STATES

Apr. 11–13: Annual meeting, National Association of Blue Shield Plans, Chicago, Ill.

Apr. 14–25: Postgraduate course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago.

April 20–25: 50th Annual Session, American College of Physicians, Conrad Hilton Hotel, Chicago, Ill.

Apr. 24–26: 31st Annual Session, American Academy of Physical Medicine and Rehabilitation, Sheraton–Chicago Hotel, Chicago.

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

June 10–13: Annual convention, Catholic Hospital Association, Minneapolis, Minn.

Oct. 25–26: North Central Medical Conference, St. Paul Hilton, St. Paul, Minn.

1969 OTHERS

Mar. 3–7: Symposium on Arthritis and Related Disorders, New York University Medical Center, New York City.

Mar. 10–12: Joint meeting for doctors and nurses, American College of Surgeons, featuring general surgery and eight surgical specialties, Sheraton–Boston Hotel, Boston, Mass.

Mar. 10–13: Annual meeting, New Orleans Graduate Medical Assembly, The Roosevelt Hotel, New Orleans, La.

Mar. 13–15: Course in Current Problems in Electroencephalography: Advances Toward Their Solution, American Electroencephalographic Society and Baylor University College of Medicine, Houston, Tex.

Mar. 16: Departure date, Hawaiian Carnival for members, their families and friends, of the North Central Medical Conference, from St. Paul, Minn., International Airport.

Mar. 17–19: 25th Anniversary Meeting, American Academy of Allergy, Americana Hotel, Bal Harbour, Fla.

Mar. 24–28: ACP postgraduate course—Modern Pathology for the Internist, University of Pittsburgh, Pittsburgh, Pa.

Mar. 26–28: Three Days of Gastroenterology, American College of Physicians, Grady Memorial Hospital Auditorium, Atlanta, Ga.

Mar. 31–Apr. 2: Psychiatry and the Internist (20th symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Apr.: AHA Council on Clinical Cardiology—"Clinical Electrocardiography and Vectorcardiography," Augusta Ga.

Apr. 9–11: Management and Care of Respiratory Insufficiency, University of Colorado School of Medicine, Denver, Colo.

Apr. 18: Annual symposium on Infectious Diseases, American Academy of General Practice, Battenfield Auditorium, Kansas City, Kan.

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

Apr. 21–25: 50th annual session, American College of Physicians, Chicago, Ill.

Apr. 28–May 1: Annual Clinical Meeting, American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Fla.

May 8–10: National Conference on Breast Cancer, American Cancer Society, Shoreham Hotel, Washington, D.C.

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MEDICAL MEETINGS *continued*

May 12–16: ACP postgraduate course—Internal Medicine, University of Pennsylvania School of Medicine (Pennsylvania Hospital), Philadelphia, Pa.

May 18–21: Annual Meeting, Pharmaceutical Manufacturers Association, The Greenbrier, White Sulphur Springs, W. Va.

June: AHA Council on Clinical Cardiology, title and location to be announced.

June 9–13: ACP postgraduate course—Neurology for the Internist, Bowman Gray School of Medicine, Winston-Salem, N.C.

June 16–19: ACP postgraduate course—Auscultation of the Heart, University of Oregon Medical School, Portland, Ore.

June 16–20: ACP postgraduate course—Hematology, University of Rochester School of Medicine, Rochester, N.Y.

July 7–11: Postgraduate Course—Clinical Electrocardiographic Interpretation, Hahnemann Medical College and Hospital, Philadelphia, Pa.

July 14–18: Postgraduate course—Interpretation of Cardiac Arrhythmias, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 11–17: Postgraduate course—Space Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 7–11: Western Conference of Prepaid Plans, Sun Valley, Idaho.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Nov. 20: Annual Membership Meeting, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psycosomatic Seminars), to South Pacific.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1969 AMA

July 13–19: Annual meeting, American Medical Association, New York City.

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

May 11–14: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1970 OTHERS

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

"New Hospital Psychiatry" Program

The University of Wisconsin Department of Postgraduate Medicine, the Department of Psychiatry, and the Wisconsin Psychiatric Institute of the University of Wisconsin Medical Center will sponsor a two and one-half day conference, June 5–7, devoted to the theme "The New Hospital Psychiatry."

This conference will be directed toward mental health professionals who are intimately involved in inpatient care and will emphasize innovative developments in the clinical operations of hospital psychiatry settings.

Some of the featured speakers will be Gene Abroms, MD, Teodoro Ayllon, PhD, Frederick Duhl, MD, Richard Grant, MD, Henry Grunebaum, MD, Nathan Kline, MD, Arnold Ludwig, MD, David Sanders, PhD, George Saslow, MD, and Carl Whitaker, MD.

For further information write: Thomas C. Meyer, MD, Chairman, Department of Postgraduate Medicine, 307 N. Charter St., Madison, Wis. 53706.

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1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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MEDICAL MEETINGS *continued*

Educational Cruise Set for December

James L. McCartney, MD is now organizing the ninth educational cruise for TIPS (Trans-International Psychosomatic Seminars) to go to the South Pacific. Scientific discussions will be held for 63 days aboard the SS President Cleveland sailing from San Francisco, Dec. 20, 1969, and then ashore at Los Angeles, Honolulu, Papeete, Pago Pago, Suva, Auckland, Sydney, Port Moresby, Bali, Singapore, Hong Kong, Manila, and Guam. This ship is fully air-conditioned, stabilized and has a passenger capacity of 682. Those interested should contact, Dr. J. L. McCartney, Director of TIPS, Box 1309, Westhampton Beach, N.Y. 11978.

TIPS is a nonprofit, nonpolitical, nonsectarian, voluntary, educational organization, with the purpose of taking up-to-date information about psychosomatic medicine to all sections of the world, when invited to do so by the local medical societies or medical schools, and to receive in exchange their comments.

Conference on Breast Cancer

The National Conference on Breast Cancer will be held at the Shoreham Hotel in Washington, D.C. Thursday–Saturday, May 8–10.

A multidisciplinary review of the breast cancer problem in the United States will be presented, including epidemiology, etiology, detection, diagnosis, management, and control measures.

Successful as well as disappointing approaches in combating the disease will be discussed in an effort to identify possible directions for future progress.

No registration fee. Preregistration requested. Address correspondence to: Roald N. Grant, MD, National Conference on Breast Cancer, American Cancer Society, Inc., 219 East 42nd St., New York, N.Y. 10017.

Battered Child Program, Denver

"Diagnosis and Care of the Battered Child" will be the subject of a two-day symposium in Denver, Colo., May 22–23, sponsored by the Office of Postgraduate Medical Education, U. of Colo. School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Sports Injuries Conference

The Fourth Annual Spring Conference on the Prevention and Management of Sports Injuries will present the greatest all-star cast in its history from all over the United States when it convenes at the Wisconsin Center, Mar. 26–27. The always popular session on taping and bandaging will occupy the entire first morning of the conference. Four head

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trainers from leading midwestern universities will demonstrate their techniques and assist all those who wish to participate in trying them out. William L. Newell of Purdue, Gayle B. Robinson of Michigan State, Richard Hoover of Northwestern, and Robert Weingart of Marquette will be the demonstrators.

Robert F. Dickey, MD, authority on the skin problems of athletes, will give illustrated lectures at two sessions on the second day of the meeting. Thomas B. Quigley, MD, physician to the Harvard University football team, and Owen B. Murphy, MD, orthopedic consultant to the University of Kentucky Athletic Department, will give talks and also participate in panel discussions on the subjects of Conditioning Athletes, Ankle Injuries, On the Field Diagnosis of Injuries and Rehabilitation of Sports Injuries. They will be joined by members of the University of Wisconsin's staff and some of the visiting trainers in the panel sessions.

For further information contact Thomas C. Meyer, MD, Chairman Postgraduate Medicine, 307 N. Charter Street, Madison, Wis. 53706.

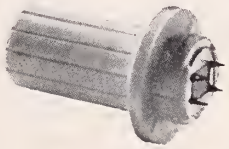
Physical Medicine and Rehabilitation

The American Academy of Physical Medicine and Rehabilitation announces its 31st Annual Session to be held Apr. 24–26 at the Sheraton–Chicago Hotel, Chicago.

SMS Members Invited to Wisconsin Dental Meeting

All members of the State Medical Society of Wisconsin are invited to attend the 99th Annual Session of the Wisconsin State Dental Society at the Milwaukee Auditorium, May 5–7. A number of fine scientific programs of mutual interest to both professions will be presented all three days. Your current membership card is all that is required to register. Registration will be conducted in the inner corridor of the Auditorium, utilizing the entrance between the Auditorium and the Arena.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
HISTO?
(Histoplasmosis—"The Masquerader")



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(Rosenthal)
The LEDERTINE™ Applicator with the Blue Handle

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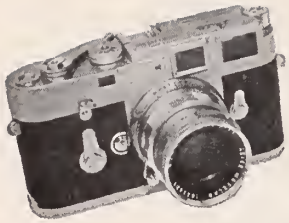


ANNUAL PHOTOGRAPHY CONTEST

OPEN TO MEMBERS OF THE STATE MEDICAL SOCIETY

EASY TO ENTER

Contest rules have been simplified to make it easier to enter your photographs.

Any black and white or color photo may be entered, either mounted, framed or unmounted. Photos may be enlarged to any size up to 16 x 20 inches, with a minimum recommended size of 5 x 7 inches.

Prizewinning photographs, if received unmounted, will be mounted on 16 x 20 boards for display at the State Medical Society Annual Meeting.

CLASSIFICATIONS

Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape, objects, still life, etc.).

ENTRIES

There is no limit to the number of entries allowed to any exhibitor. All entries must be at the State Medical Society headquarters in Madison by April 1, 1969.

Entries must carry the following information on the back of the photo or mounting board: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or any photo. All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

AWARDS

Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

JUDGING

Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

MAIL THIS ENTRY AND ALL PHOTOS TO:

PHOTO CONTEST, State Medical Society of Wisconsin,
Box 1109, Madison, Wis. 53701

Name _____

Address _____

CLASS	NUMBER ENTERED (Black & White)	(Color)	TOTAL
Medicine	_____	_____	_____
Travel	_____	_____	_____
People	_____	_____	_____
Animals	_____	_____	_____
Pictorial	_____	_____	_____

WISCONSIN MEDICAL JOURNAL
VOL. 68, NO. 2 FEBRUARY 1969

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Health Legislation Introduced to Draw Attention; State Medical Society Outlines Position on First Bills

Health care legislation promises to be a significant part of the "action" during the 1969–70 session of the Wisconsin Legislature.

At the rate bills are being introduced it appears that nearly 200 of the expected 1300 bills and resolutions will relate to health and medicine.

Among the bills of interest to the medical profession are the following already in the legislative "hopper":

ASSEMBLY BILLS:

AB- 4 . . . . Uniform Anatomical Gifts Act—This bill is designed to clarify who may make a gift of all or part of his body after death, who may receive such gifts, the purposes for which they may be received, and the procedures for making an anatomical gift. The bill does not apply to living persons who provide an anatomical part used in a transplant, such as a kidney. The State Medical Society supports this legislation in principle.

AB- 16 . . . . Slow Moving Vehicle Emblem—Requires all vehicles (bicycles excepted) designed for use at speeds of 25 miles per hour or less on public highways to display a standard SMV emblem. SMS supports.

AB- 20 . . . . Psychology Licensing—Creates a psychology examining board to license psychologists and limits the use of the terms "psychologist" and "psychological" to those licensed under the bill. It was introduced by Assemblymen Weisensel (Sun Prairie) and Molinaro (Kenosha), co-sponsored by Senators Hollander (Rosendale) and Schreiber (Milwaukee), at the request of the Wisconsin Psychological Association. Referred to Assembly Committee on Judiciary. The Council of the State Medical Society has stated that if persons licensed as psychologists treat the sick, they should be required to pass basic science examinations and be subjected to the same standards of care as are imposed on physicians.

continued on page 28

Urge Interest in Religion and Medicine by County Societies

The state's local medical societies are being urged to provide "a meeting ground for man's spiritual and physical concerns."

This was the principal message coming out of a recent meeting of the State Medical Society's newly created Committee on Medicine and Religion.

After its first session, the committee called upon county societies to encourage contact between physicians and clergymen with a view to exploring the medical–spiritual implications of health care.

Interested physicians may call upon the State Society committee for information and assistance.

The committee includes Drs. John O. Simenstad, Osceola, chairman; R. W. Shropshire, Madison; F. J. Cerny, Fond du Lac; Maxwell Weingarten, Milwaukee, and Joseph R. Matt, Oconomowoc.

ANNUAL MEETING: May 12–15

Watch the March issue of *WMJ* for a complete program of the State Medical Society annual meeting in Milwaukee.

Hobby Show Helps Health

Hobbies are healthful. Almost every health advisor suggests the need of a personal hobby for a "change of pace" and geneal relaxation.

And hobbies are being encouraged by the CES Foundation. With displays at the Society headquarters in Madison and the Stovall Hall of Health in Prairie du Chien, the Foundation emphasizes "Hobbies for Health." Showings include cuff links, stamps, bottles, fishhooks, shells, bells, buttons, glass, dolls, rocks, eggshell art, and a myriad of other hobbies engaged in by physicians and their families and others.

What's your hobby? Let the CES Foundation display it—perhaps it could help someone to better health.

MEDICAL STUDENT LOANS ARE HELPING BUT . . .

The medical profession is itself making a big dent in the problem of helping medical students meet the financial needs of their education.

The medical student loan fund of the State Medical Society's Charitable, Educational and Scientific Foundation currently has more than $176,000 out on loan to 131 medical students. But it could loan out double or triple that if funds were available. Physicians and others interested in helping are urged to contact the Foundation.

The American Medical Association has a similar fund, but it operates only to guarantee bank loans made at usual rates. To date it has assisted more than 20,000 medical students who have borrowed a total of over $45,000,000.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others.

Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1968 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

HEALTH LEGISLATION *continued from page 27*

AB- 33 . . . . Abortion—Repeals the existing statute thereby permitting abortion without criminal limitation. Existing statute permits only "therapeutic abortion performed by a physician" when it is necessary or advised by 2 other physicians in order to save the life of the mother and is performed in a licensed maternity hospital. The bill was introduced by Assemblyman Barbee (Milwaukee) and referred to the Assembly Committee on Public Welfare. The State Medical Society holds that the present law as it pertains to abortion is satisfactory from the medical standpoint. It takes the position that the moral or other aspects of abortion are not the province of the medical society.

AB- 97 . . . . Chiropractic under Title 19—Adds the services of chiropractors to the state's program of medical assistance for the medically indigent and recipients of the categorical aids. Introduced by Assemblymen Bock (Highland), Gee (Wisconsin Rapids), Tobiasz, Lipscomb and Jones (Milwaukee), McDougal (Oconto Falls), Bradley (Oshkosh), Byers (Marion), Schwefel (Oakfield), Warren (Racine), Conradt (Shiocton), and Laper (Rock Springs). Referred to Assembly Committee on Public Welfare. State Medical Society opposes.

AB-125 . . . . County Medical Committees—Creates a committee of physicians in each county to screen medical certificates in connection with applications for driver's licenses by epileptics. Introduced by Assemblyman York (River Falls). Referred to Assembly Committee on Highways.

AB-131 . . . . Measles Immunization—Permits the Department of Health and Social Services to conduct a statewide voluntary immunization program to eliminate measles. Referred to Assembly Committee on Public Welfare.

SENATE BILLS:

SB-30 and SB-56 . . . . The So-called "Family Planning" Bills—SB-30 removes contraceptives from the classification of indecent articles; limits the sale of contraceptives to pharmacists and physicians, and does not prohibit their sale to unmarried persons. SB-56, introduced by the Legislative Council, limits the sale of contraceptive articles to pharmacists and physicians, prohibits their sale to unmarried persons, and establishes regulations relating to the distribution of family planning information to married individuals or those about to be married.

SB-39 and SB-40 . . . . Marquette School of Medicine Aid—Seeks to pave the way for state financial aid to Marquette. Introduced by the Joint Committee on Finance, the bills would ultimately result in appropriation of 3.2 million dollars to Marquette School of Medicine. Under the bills, one-third of the members of the Trustees of Marquette medical school would be nominated by the Governor. The State Medical Society is on record as favoring aid to the continued operation of Marquette Medical School with state funds.

Physicians are urged to contact their legislators concerning these and other bills in which they are interested.

List Legislative Committees Hearing Health-Care Bills

Eight committees of the State Legislature are of special importance to the medical profession during the 1969–70 sessions.

The education, public welfare, judiciary and finance committees in each house receive most of the bills relating to health and medical care.

Physician contacts made with the members of these committees are especially valuable to provide the legislators with background information and opinion for use in hearings on bills and in making recommendations to the full Assembly or Senate.

SENATE COMMITTEES

Education:

Holger B. Rasmusen (R-Spooner), Chairman
Nile W. Soik (R-Whitefish Bay), Vice-Chairman
Raymond F. Heinzen (R-Marshfield)
Carl W. Thompson (D-Stoughton)
Martin J. Schreiber (D-Milwaukee)

Public Welfare:

Arthur A. Cirilli (R-Superior), Chairman
Holger B. Rasmusen (R-Spooner), Vice-Chairman
Walter J. Chilsen (R-Wausau)
Raymond F. Heinzen (R-Marshfield)
Norman Sussman (D-Milwaukee)

Judiciary:

Allen J. Busby (R-Milwaukee), Chairman
Raymond C. Johnson (R-Eau Claire), Vice-Chairman
Arthur A. Cirilli (R-Superior)
Leland S. McParland (D-Cudahy)
Fred A. Risser (D-Madison)

Finance:

Walter G. Hollander (R-Rosendale), Chairman
Chester E. Dempsey (R-Hartland), Vice-Chairman
Alex J. Meunier (R-Sturgeon Bay)
James D. Swan (R-Elkhorn)
Henry Dorman (D-Racine)

ASSEMBLY COMMITTEES

Judiciary:

George B. Belting (R-Beloit), Chairman
Jon P. Wilcox (R-Wautoma), Vice-Chairman
Kyle Kenyon (R-Tomah)
William G. LaFave (R-Peshtigo)
F. James Sensenbrenner, Jr. (R-Shorewood)
Jack D. Steinhilber (R-Oshkosh)
Robert O. Uehling (R-Madison)
Norman C. Anderson (D-Madison)
Frank L. Nikolay (D-Abbotsford)
John E. McCormick (D-Milwaukee)
Frederick D. Kessler (D-Milwaukee)

Public Welfare:

Harvey F. Gee (R-Wis. Rapids), Chairman
Carolyn J. Blanchard (R-Edgerton), Vice-Chairman
Gerald A. Greider (R-La Crosse)
John Parkin (R-Marshfield)
Joseph E. Tregoning (R-Shullsburg)
John C. Van Hollen (R-Chetek)
Stanley York (R-River Falls)
William J. Rogers (D-Kaukauna)
Manny S. Brown (D-Racine)
Cletus Vanderperren (D-Green Bay)
Dennis Conta (D-Milwaukee)

Education:

Lawrence H. Johnson (R-Algoma), Chairman
Stanley York (R-River Falls), Vice-Chairman
Willis J. Hutnik (R-North Ladysmith)
George H. Klicka (R-Wauwatosa)
Oscar A. Laper (R-Rock Springs)
Esther S. Luckhardt (R-Horicon)
Ervin F. Schneeberg (R-Brown Deer)
John C. Van Hollen (R-Chetek)
David R. Obey (D-Wausau)
Bruce S. Peloquin (D-Chippewa Falls)
Herbert J. Grover (D-Shawano)
Manny S. Brown (D-Racine)
Ernest J. Korpela (D-Washburn)

Finance:

Byron F. Wackett (R-Watertown), Chairman
David O. Martin (R-Neenah)
Kenneth J. Merkel (R-Brookfield)
Russell A. Olson (R-Bassett)
John C. Shabaz (R-New Berlin)
Merrill Stalbaum (R-Waterford)
Tommy G. Thompson (R-Elroy)

HEALTH SERVICES SURVEY

A household survey on the use of health services is nearing completion in Central Wisconsin.

Wisconsin State University—Stevens Point reports that results of the five-county survey centered around Marshfield will be available April 1.

The survey is designed to reveal what residents of the area feel they need and want in the way of health care, and how much they think they are getting and from whom.

REGIONAL REPS READY TO HELP

Four representatives of the Regional Services Division of the State Medical Society are prepared to provide services to county medical societies and individual physicians throughout the state. Under direction of John C. LaBissoniere who is based at the Madison headquarters, the team acts as liaison between the membership and headquarters.

The representatives and their territories are as follows:

JOHN C. LABISSONIERE, Box 1109, Madison 53701; tel. (608) 257–6781. *Southern*—Milwaukee, Racine, Kenosha, Walworth, Rock, Green, Lafayette, Grant, Iowa, Dane, Sauk, Richland, and Crawford counties.

ERIC P. JACOBSON, 801 W. Browning St., Appleton 54911; tel. (414) 739–4060. *Eastern*—Door, Kewaunee, Brown, Outagamie, Winnebago, Calumet, Manitowoc, Fond du Lac, Sheboygan, Dodge, Washington, Ozaukee, Jefferson, and Waukesha.

GLENN C. WALDSCHMIDT, 9010 Reed Road, Rothschild 54474; tel. (715) 359–4112. *Central*—Columbia, Green Lake, Marquette, Adams, Waushara, Wood, Portage, Waupaca, Clark, Marathon, Menomonie, Shawano, Taylor, Lincoln, Langlade, Oconto, Price, Oneida, Vilas, Forest, Florence, and Marinette.

ELMER B. SANDEEN, 306 W. Military Rd., Rothschild 54474; tel. (715) 359–5881. *Western*—Vernon, La Crosse, Monroe, Juneau, Jackson, Trempealeau, Buffalo, Pepin, Pierce, Eau Claire, St. Croix, Dunn, Chippewa, Polk, Barron, Rusk, Burnett, Washburn, Sawyer, Douglas, Bayfield, Ashland, and Iron.

Society members are urged to utilize their services.

Chiropractic Inadequacies and Dangers Told in HEW Report to Congress

In one of his final acts as Secretary of the Department of Health, Education and Welfare, Wilbur J. Cohen sent to the U.S. Congress a lengthy report declaring that chiropractors are unprepared to "make an adequate diagnosis and provide appropriate treatment."

The report was presented on Dec. 28, 1968, after the Congress had requested a study to help it determine whether to include chiro benefits in Medicare.

Cohen urged rejection of chiropractic services under Medicare.

The report, one of the first independent studies of its type in the nation, makes the following "conclusions and recommendations:"

"1. There is a body of basic scientific knowledge related to health, disease, and health care. Chiropractic practitioners ignore or take exception to much of this knowledge despite the fact that they have not undertaken adequate scientific research.

"2. There is no valid evidence that subluxation, if it exists, is a significant factor in disease processes. Therefore, the broad application to health care of a diagnostic procedure such as spinal analysis and a treatment procedure such as spinal adjustment is not justified.

"3. The inadequacies of chiropractic education, coupled with a theory that de-emphasizes proven causative factors in disease processes, proven methods of treatment, and differential diagnosis, make it unlikely that a chiorpractor can make an adequate diagnosis and know the appropriate treatment, and subsequently provide the indicated treatment or refer the patient. Lack of these capabilities in independent practitioners is undesirable because: appropriate treatment could be delayed or prevented entirely; appropriate treatment might be interrupted or stopped completely; the treatment offered could be contraindicated; all treatments have some risk involved with their administration, and appropriate treatment exposes the patient to this risk unnecessarily.

"4. Manipulation (including chiropractic manipulation) may be a valuable technique for relief of pain due to loss of mobility of joints. Research in this area is inadequate; therefore, it is suggested that research that is based upon the scientific method be undertaken with respect to manipulation.

"RECOMMENDATION

"Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the Medicare program."

There's More To It Than Doctor Shortage

Amid talk of solving the doctor shortage with everything from sweepstakes to free fishing licenses, a physician and a housewife stole the "show" at a recent conference on the doctor shortage held at the State Medical Society.

"Let's never forget that the State Medical Society is holding this conference in an effort to benefit all the people of Wisconsin," said Dr. Russell Lewis, Marshfield.

The housewife, president-elect of the Woman's Auxiliary to the State Medical Society, Mrs. W. J. Smollen, Racine, adjusted the meeting's focus when she said:

"The problem is more acute than a shortage of physicians. It is a problem of social concern with housing, education, and employment. We must combine our attack with social workers, psychologists, and many related health workers, or we'll never succeed."

Society Urges Continued Efforts to Inform Public of Chiropractic

Efforts to inform the public about chiropractic continue by the medical profession at all levels, but chiropractors, too, are continuing their own campaign.

On the opposite page is one such advertisement recently published in a Minnesota newspaper.

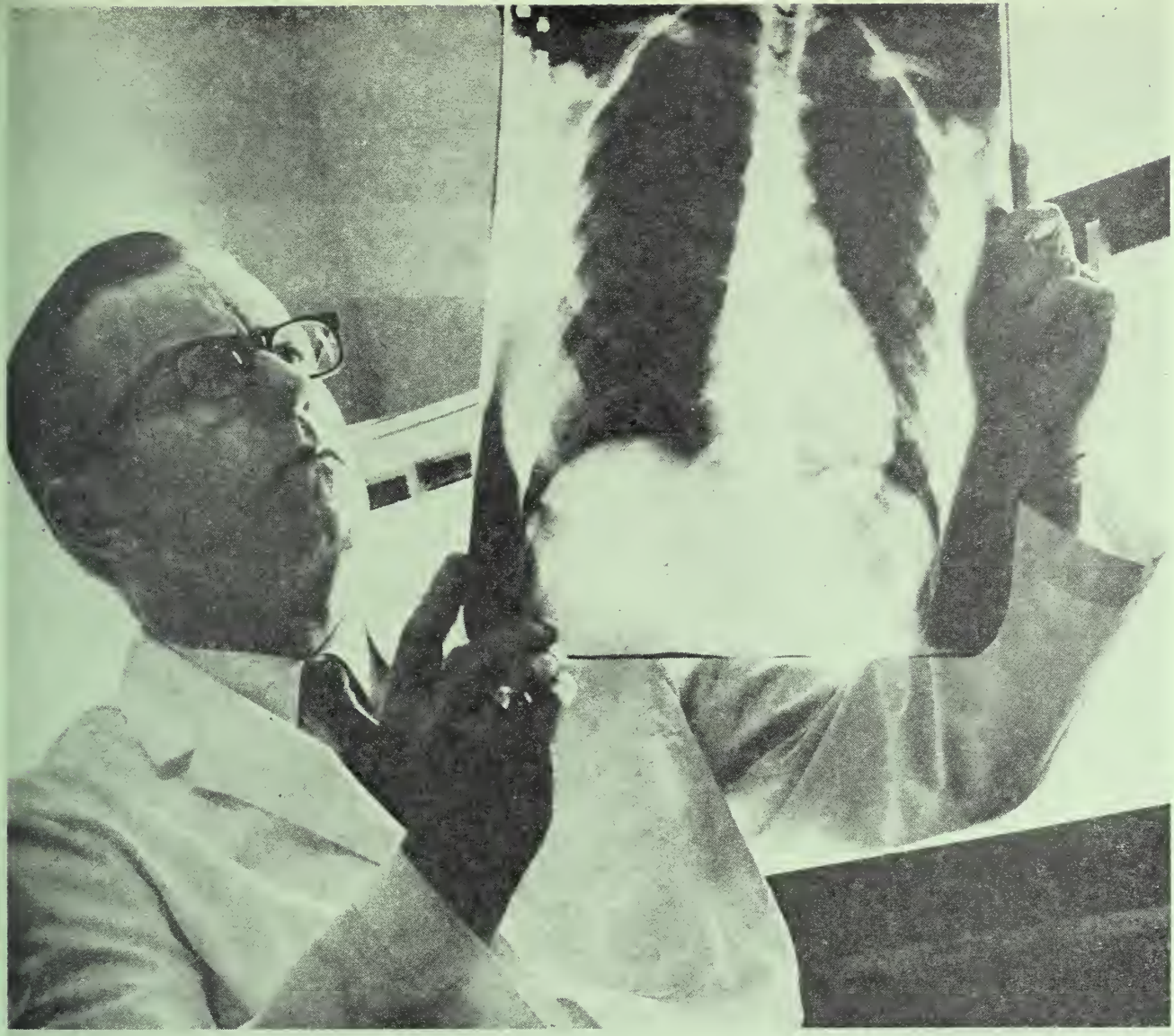
The State Medical Society urges all physicians to review the Statement of Policy on Chiropractic adopted by the American Medical Association House of Delegates, November 1966, which follows:

"It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation.

"In 1965, a United States District Court, in upholding a state's constitutional right to refuse to license chiropractors, said that 'since chiropractic claims to be a complete and independent healing art capable of curing almost all kinds of disease, the state Legislature may have felt that the requirement of a foundation in materia medica and surgery . . . would be a protection to the public.' Without dissent, the United States Supreme Court affirmed the decision.

"The wisdom of these decisions by the nation's highest courts justifies the medical profession's educational program of alerting the nation to the public health threat posed by the cult of chiropractic.

"Patients should entrust their health care only to those who have a broad scientific knowledge of diseases and ailments of all kinds, and who are capable of diagnosing and treating them with all the resources of modern medicine. The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as life saving vaccines, often ends with tragic results."



What is a Chiropractor?

When you understand that, you'll understand better how he can help you.

He's a Doctor.

Six years of intensive study and on-the-job internship precede his climactic moment as a student Doctor — the State Boards — and the License — Doctor of Chiropractic. His areas of study include some of the most advanced fields in science — anatomy, bacteriology, pathology, physiology, biochemistry, pediatrics, geriatrics, spinal manipulation.

He's trained in a special area—your spine.

The special concerns of your Doctor of Chiropractic are the spine and other articulations of the body. He is concerned with body mechanics and the interplay of body structure with the functioning of the nervous system.

It has been recognized how vital perfect spinal alignment is to well-being and to general body health. A misaligned vertebra can cause excruciating pain in the immediate back area. But it can also exert an effect on the nerves leading from the spine — and thereby affect distant portions of the body.

This is the specialty of your Doctor of Chiropractic.

He's able to diagnose.

Research in all fields of health has advanced rapidly in the past few years. In Chiropractic, it has been dramatic.

Today your Doctor of Chiropractic has at his disposal the most advanced techniques and equipment in modern X-Ray, laboratory and diagnostic instrumentation.

He is thoroughly trained and skilled in orthopedic and neurological procedures.

He may be your answer.

Sleepless nights, pain-wracked days may be agonies you need not endure.

A visit to your Doctor of Chiropractic may open the way to the relief you seek.

He will examine and analyze you Chiropractically to determine what nerve irritation you may have existing in your body. He will then thoroughly explain your condition to you and, with your permission, proceed with your case on a Chiropractic basis.

One visit can reveal much. Consider it.

Minnesota Chiropractic Association

SMS Hot Line

IN MADISON—The State Medical Society expects legislation on laboratory licensure, chiropractic, blood banks, implied consent, medical examiner system, and proposals to license opticians, ambulance drivers and hearing aid dealers . . . . and others. County Society presidents, secretaries, delegates and alternates, and legislative chairmen will receive bulletins to keep members up-to-date on these matters.

GOVERNOR KNOWLES—In a "policy position" statement elaborating on his budget message, recommends legislation "eliminating the requirement to pay usual, customary and reasonable charges under Medicaid (Title 19) plus restriction of "free choice." He does not recommend reduction in services or eligibility "because it would deny essential health services to the poor."

DOCTOR DRAFT CALL—Wisconsin's quota for the impending 1969 doctor draft has not yet been announced but is expected to be less than half of last year's. Even so, there may not be enough non-reserve interns to meet the demand.

MARK THE DATES OF MAY 13-15—Annual scientific sessions of the State Medical Society in Milwaukee. Tuesday—Outstanding Internal Medicine program featuring radiologists and internists. Wednesday—An AAGP Credit program based on the findings of the SMS Maternal Mortality Study. Thursday afternoon—Sen. Gaylord Nelson speaks.

WISCONSIN LEGISLATORS—Have been sent personal copies of the January 1969 Wisconsin Medical Journal "Blue Book" issue. It contains information about the State Medical Society, useful resource material on ethics, malpractice, narcotics, laws on LSD, drugs, epilepsy and driving, workmen's compensation, and the like. It also contains a directory of members of the Wisconsin Legislature.

DISABILITY PROTECTION FOR MEMBERS—The Society-sponsored Provident Disability plan now has more than 1900 practicing physicians enrolled. Last year, the plan paid benefits to disabled physicians totalling more than $232,000. Good protection . . . worth having . . . worth keeping.

WPS Health-Care Charge Card Offered Feb. 1

Public offering of the new WPS HEALTH-CARE CHARGE CARD began this month with all WPS groups.

The card will provide "instant credit" for up to $500 of health services or personal health care items not covered by WPS health insurance programs.

Initially, the CHARGE CARD is available to any group presently covered by Wisconsin Blue Shield (WPS).

The card may be used to cover charges for professional services, institutional facilities, materials and supplies as these are recognized by the medical profession and related to the health care of the cardholder or his dependents.

Physicians, pharmacists, and hospitals will be contacted in the near future to inform them of the new program and how they may utilize it.

When a group accepts the CHARGE CARD service, each employe who has Wisconsin Blue Shield (WPS) coverage will be issued a WPS HEALTH-CARE CHARGE CARD.

When the cardholder wishes to use the card, he presents his CHARGE CARD to the physician, hospital, pharmacist, or other authorized provider who in turn will bill WPS Health-Care Charge Card Corporation for payment.

The Charge Card Corporation will pay providers directly and promptly on the basis of their "customary, usual and reasonable charges."

The cardholder, in turn, will receive a monthly statement of the health-care expenses he has charged. He may pay the full balance within 30 days without interest. If he wishes to spread the payments over a longer period, he will pay 1% per month on the unpaid balance.

Jack R. Possman, Madison, executive vice-president of the WPS Charge Card Corporation, points out that "even those people who have basic or special WPS–Blue Shield coverage do not have total protection for the costs of health care."

"When some unexpected health condition develops, they need a breathing period on costs at the time when their chief concern should be the best possible care for early recovery," he says.

"The WPS combination of insurance benefits and postpayment gives them that security," he believes.

The HEALTH-CARE CHARGE CARD is operated by a separate corporation, wholly owned by WPS. Members of the Board of Directors of the corporation are: Drs. Paul B. Mason, Sheboygan, president; William D. James, Oconomowoc; Robert E. Callan, Milwaukee; and John T. Sprague, Madison, treasurer.

Drs. E. M. Dessloch, Prairie du Chien; Milton Finn, Superior; D. N. Goldstein, Kenosha; and Robert Krohn, Black River Falls.

Messrs. E. E. Bryant of the Nelson Muffler Corporation, Stoughton, vice-president; Sylvester H. Dretzka, former secretary of the State Board of Pharmacy, Milwaukee; Attorney Charles L. Goldberg, Milwaukee; George Molinaro, president of the American State Bank, Kenosha; and Dayton F. Pauls, president of the Citizen's Bank, Sheboygan.

Attorney R. B. Murphy, Madison, secretary; H. B. Maroney, Madison, assistant secretary; and Jack R. Possman, Madison, executive vice-president.

Blue Shield Offers Youth Films on Sex and Drugs

A flood of requests for "Youth on a 4-Day Trip" films and audiotapes is coming to the State Medical Society as a result of Work Week of Health–1968.

Already more than 1,400 requests for film showings have been received.

Through a grant from Wisconsin Blue Shield (WPS) it was possible to make videotapes during the Work Week of Health last October.

Six 16mm films (marijuana, LSD, sex, smoking, alcohol, and "how to kick the habit") are now available. Each is a one-hour presentation.

For more information contact: Wisconsin Blue Shield, Box 1109, Madison, Wis. 53701.

Dear Doctor: HELP!

Help your office to receive faster payment of the claims you submit under Medicare Part B.

Help relieve your office force of needless work and worry about Medicare claims.

Help WPS (as a Medicare Part B carrier) to reduce the time lag in payment for physicians' services under Medicare.

Here's the problem: Every working day Wisconsin Blue Shield (WPS) receives over 3,000 Medicare claims for processing. Every day almost 200 of these have to be returned to the physician because they are so incomplete that it is impossible even to begin the process of payment.

Here's what you can do to help:

1. Be sure to obtain the Health Insurance Claim Number *directly* from the beneficiary's Medicare card.
2. Make certain that *all* digits and letter suffixes are included.
3. Use the beneficiary's name *exactly* as shown on the Medicare card. Example: If the card says J. L. Jones, don't report James L. Jones.
4. Ask the beneficiary for and then report his house number, street or RFD, city, and zip code.

If your office will provide the information requested in these four points, most of the major processing delays will be eliminated.

PLACEMENT SERVICE READY TO HELP

These communities are listed with the Placement Service of the State Medical Society as seeking physicians. Anyone interested, please contact the State Society in Madison.

Abbotsford, Albany, Antigo, Ashland, Baraboo, Barron, Beaver Dam, Beloit, Berlin, Big Bend, Black River Falls, Blanchardville, Bloomer, Boyd, Burlington, Cambria, Campbellsport, Casco, Cedarburg, Chippewa Falls,

Eau Claire, Elroy, Fond du Lac, Fox Lake, Frederic, Fredonia, Fremont, Gillett, Gilman, Green Bay, Greendale, Greenwood, Hayward, Hazel Green, Hollandale, Horicon, Iola, Janesville, Kenosha, La Crosse, La Farge, Lake Geneva, Lancaster, Loganville, Lomira, Loyal,

Madison, Manitowoc, Markesan, Marshfield, Medford, Menasha, Mendota, Menomonie, Merrill, Milwaukee, Monroe, Mosinee, Neenah, New Holstein, New Lisbon, New London, New Richmond, Oshkosh, Park Falls, Peshtigo, Phelps, Phillips, Platteville, Plymouth, Port Washington, Prairie du Sac, Pulaski,

Racine, Reedsburg, Reedsville, Rhinelander, Rio, Rosendale, Saukville, Sharon, Shawano, Sheboygan, Sheboygan Falls, Shullsburg, Silver Lake, Spooner, Stoughton, Sun Prairie, Superior, Sussex,

Tigerton, Tomah, Tomahawk, Trempealeau, Two Rivers, Watertown, Waukesha, Waupun, West Bend, Whitehall, Whitewater, Winnebago, and Wisconsin Dells.

ALUMNI DONATIONS HELP MED SCHOOLS

The generosity of practicing physicians goes a long way to help the nation's medical schools with their budgetary problems.

Through the American Medical Association–Education Research Foundation (AMA–ERF) these physicians have contributed more than $19,000,000 as "unrestricted grants" to medical schools in the past few years.

In 1967, for example, Marquette School of Medicine received $12,124 in unrestricted grants from AMA-ERF. The University of Wisconsin Medical School received a check for $8,576.

These funds came from graduates of both schools and others who were interested. Of course, each school received many other contributions direct from its graduates.

Where Are the Doctors and Hospital Beds in Wisconsin?

The latest statistical information on this subject comes from a publication called "Distribution of Physicians, Hospitals, and Hospital Beds in the U.S., 1967," published by the American Medical Association. The figures were for the period ending Dec. 31, 1967. Distribution figures in Wisconsin are shown in the table at the right.

WPS INCOME $28 MILLION

Wisconsin Blue Shield (WPS) ended 1968 with total premium income of $28,144,000, according to preliminary reports made to the State Medical Society's Commission on Medical Care Plans.

Distribution of Patient-Care Physicians, Hospitals and Hospital Beds in Wisconsin: 1967

COUNTY	Patient-Care Physicians TOTAL	Number of Hospitals	Number of Hospital Beds	Resident Population January 1, 1967
		December 1, 1967		
Adams	2	1	35	7,400
Ashland	14	2	149	16,700
Barron	20	4	199	33,700
Bayfield	1	1	29	11,300
Brown	130	4	738	150,700
Buffalo	8	1	49	14,100
Burnett	2	1	30	9,100
Calumet	9	1	60	26,500
Chippewa	25	3	227	47,000
Clark	16	1	56	31,600
Columbia	28	2	218	38,600
Crawford	10	2	114	15,600
Dane	690	5	1,723	266,100
Dodge	40	2	258	61,400
Door	11	1	57	20,600
Douglas	25	3	299	43,900
Dunn	11	1	85	25,000
Eau Claire	72	2	569	60,600
Florence				3,200
Fond du Lac	84	4	530	82,100
Forest	4	1	20	6,700
Grant	28	5	214	45,600
Green	46	1	170	25,000
Green Lake	13	1	78	16,500
Iowa	8	2	117	18,300
Iron	1			6,300
Jackson	6	1	52	15,300
Jefferson	32	2	180	54,600
Juneau	9	1	47	18,300
Kenosha	79	2	503	113,300
Kewaunee	10	2	74	18,500
La Crosse	117	4	755	74,100
Lafayette	4	1	36	18,600
Langlade	14	1	84	19,600
Lincoln	15	2	164	22,600
Manitowoc	61	3	353	81,500
Marathon	71	2	378	96,600
Marinette	18	1	119	34,500
Marquette	3			8,400
Menominee				2,700
Milwaukee	1,638	20	5,174	1,071,900
Monroe	13	2	124	31,600
Oconto	11	2	90	25,100
Oneida	22	2	184	23,400
Outagamie	93	4	537	115,500
Ozaukee	25			45,800
Pepin	4	1	39	7,900
Pierce	16	2	125	24,000
Polk	23	4	189	25,500
Portage	28	1	165	42,900
Price	9	1	70	13,700
Racine	126	3	552	166,800
Richland	11	1	79	15,200
Rock	115	3	479	125,300
Rusk	5	1	65	13,900
St. Croix	17	3	110	32,200
Sauk	24	3	189	38,300
Sawyer	4	1	29	9,200
Shawano	16	2	107	34,300
Sheboygan	71	3	427	92,900
Taylor	6	1	50	17,200
Trempealeau	14	3	136	24,100
Vernon	15	2	105	24,200
Vilas	7	2	42	9,500
Walworth	37	1	124	56,700
Washburn	6	2	64	9,900
Washington	28	2	162	57,400
Waukesha	174	4	477	200,400
Waupaca	22	5	260	36,800
Waushara	8	2	62	12,700
Winnebago	113	2	570	118,800
Wood	101	2	431	64,500
WISCONSIN	4,539	160	19,986	4,249,800

NEWS HIGHLIGHTS

Dr. Bump Honored by Associates

Dr. Warner S. Bump,* Rhinelander physician for 40 years, recently was honored by his associates in the Bump Medical Group. Doctor Bump came to Rhinelander in 1928 and became associated in practice with the late Dr. C. A. Richards. He had graduated from Rush Medical College, Chicago, in 1923, interned at St. Luke's Hospital, Chicago, and had been on the surgical staff for five years. He taught at Rush Medical College and also at the Northwestern University Medical School.

Warner S. Bump, MD

He founded the Bump Medical Group and is chief-of-staff of St. Mary's Hospital in Rhinelander. For many years he has been on the teaching staff of the University of Wisconsin Medical School as a preceptor, and he is the oldest physician in point of service in this capacity.

Doctor Bump has served as secretary and president of the Wisconsin Surgical Society and as secretary of the Wisconsin Surgical Travel Club. He has been a member of the American College of Surgeons since 1932 and has served on the board of governors of the college as representative from Wisconsin.

Doctor Bump was chairman of the Committee on Cancer of the State Medical Society and chairman of the executive committee of the Wisconsin Division of the American Cancer Society. He also has been a member of the national board of directors of the American Cancer Society.

WPS-BLUE SHIELD AWARDED PLAQUE

For the second year in a row, Wisconsin Blue Shield (WPS) has received a National Blue Shield award for achieving the largest gain in enrolled contracts of all equivalent-size Blue Shield plans.

WPS, the insurance division of the State Medical Society of Wisconsin, added 54,974 new members for a net gain of 12.4 percent. During the same period all plans in Category III, which includes all Blue Shield plans with 200,000 to 500,000 members, added 405,700 members for a net gain of 5.7 percent.

According to Dr. E. M. Dessloch,* chairman of the Society's Commission on Medical Care Plans, which directs the operation of WPS, "WPS success can be attributed to a combination of new groups enrolled plus retaining an unusual percentage of enrolled groups."

INTERNATIONAL SURGICAL DIGEST Abstracts WMJ Articles

Two articles which were originally published in the Wisconsin Medical Journal were abstracted in the November 1968 issue of the International Surgical Digest, a publication of the Hoeber Medical Division of Harper & Row, Publishers. The articles are: "Augmentation Mammaplasty" by Dr. Donald M. Levy* of Milwaukee and "Ovarian Pregnancy Removed Via Culpotomy" by Dr. Carl J. Levinson* of Milwaukee. Both appeared in the July 1968 issue of WMJ.

PHYSICIAN BRIEFS

Dr. Anthony R. Curreri*

. . . chairman of the surgery department, UW Medical School, Madison, will serve as consulting editor to a new medical journal dealing with malignant disease. The JOURNAL OF SURGICAL ONCOLOGY is scheduled to begin publication this year.

Dr. George Nemec*

. . . Cambridge, has been named chief-of-staff of Fort Atkinson Memorial Hospital.

Dr. George H. Stevens*

. . . Wausau, has been elected president of the Wisconsin Valley Chapter of the American Academy of General Practice for the year 1969.

Dr. Joseph M. Freeman*

. . . Wausau, was honored for 50 years of dedicated service as a practitioner at the annual meeting recently of the Wisconsin Valley Chapter of the American Academy of General Practice.

Dr. Michael J. Miech

. . . has joined the medical staff of the Red Cedar Clinic, Menomonie. A native of Sheridan, Wyo., he received his MD degree from Northwestern Medical School of Chicago, took a medical internship at Charles T. Miller Hospital in California, and fulfilled his military obligation with the U.S. Coast Guard from July 1961 to July 1963. Since that time he had been engaged in general practice at Hardin, Mont.

Dr. Roman E. Galasinski*

. . . Milwaukee, has been appointed a member of the AMA's Committee on Disaster Medical Care of the Council on National Security.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dr. Timothy A. Manning

. . . in December moved to Beloit from Cathlamet, Wash., and began practicing with Drs. G. C. Matthews* and R. R. Schwaegler.* He graduated from the University of Illinois in 1953 and after interning at Tacoma established his practice in Cathlamet. Doctor Manning was born in Washburn, Wis., and was raised in the Chicago area.

Dr. Donald C. Ausman*

. . . was elected president of the Deaconess Hospital medical staff in December. Dr. Jack D. Spankus* was named vice-president; Dr. Thomas F. Garland,* secretary–treasurer; and Dr. Stanley W. Hollenbeck,* representative at large. All are from Elm Grove.

Dr. Ramon L. Lange*

. . . professor of medicine and chief of cardiology at Marquette School of Medicine, and James D. Horgan, professor of electrical engineering at Marquette University, described Milwaukee County General Hospital's computerized intensive care monitoring system at a recent meeting of the American Heart Association in Miami Beach, Fla. The two men have developed the system which is believed to be one of two of its kind in this country.

Dr. Ruben Altman

. . . has joined the Marshfield Clinic staff following three years with the Air Force Medical Corps at Andrews Air Force Base Hospital in Washington where he served first as cardiologist and then as chief of cardiology. He received his MD degree in 1961 from Harvard Medical School, completed an internship at George Washington University Hospital, and had three years residency work in the Washington area.

Dr. Oscar A. Sander*

. . . Milwaukee, has been reappointed a member of the AMA's Committee on Rating of Mental and Physical Impairment. He also has been reappointed chairman of the Subcommittee on Hematopoietic and Lymphatic Systems of the above named Committee.

Nelson Muffler Grant Aids Students

The Nelson Muffler Corporation in December established a medical scholarship fund to be administered by the State Medical Society's Charitable, Educational and Scientific Foundation.

The grant to the Foundation is earmarked for use by medical students who have graduated from high schools in Neillsville, Stoughton, Mineral Point, Black River Falls, Viroqua, and Bloomer—communities in which the Nelson Muffler Corporation has operations.

In making the grant, Mr. D. W. Gjeston, Stoughton, president of NMC Projects, Inc., and treasurer of the Nelson Muffler Corporation, stated, "We hope that this grant will encourage young men and women from these communities to go to medical school and return to their home areas to practice their profession."

"In these days of high costs," he said, "Nelson Muffler Corporation hopes its contribution will lend a helping hand when a local medical student needs it most."

ARTHRITIS TEACHING TO BE EXPANDED

The board of the Arthritus Foundation of Wisconsin late last year approved a proposal to expand the teaching programs in rheumatic diseases and set a goal of $125,000 to implement and prepare a professional team recruitment plan.

The foundation currently gives about $13,000 annually to the program which is conducted under Marquette medical school at Milwaukee County General Hospital, Veterans Administration Hospital (Wood), Columbia Hospital, and the Curative Workshop.

With expansion, the program would be extended to several other community hospitals. Full time professional staff members would be hired.

The foundation's executive director, Donald L. McNeil, has stated that the board's action constituted a step toward an arthritis clinical research center as part of the proposed southeastern Wisconsin medical center.

The board proposed that formal liaison be established with the Wisconsin Regional Medical Program advisory committee, the medical center steering committee, and the two Wisconsin medical schools.

According to Mr. McNeil, a fund drive will be initiated in May to augment contributions from the United Fund of which the foundation is a member agency.

'Battered Child' Syndrome

Under Wisconsin law, medical personnel, social workers, and school administrators are obligated to report when they have reason to believe that a child has or is having abuse inflicted upon him, Dr. E. H. Jorris,* state health officer, stated recently.

Under this law, 235 instances were reported in 1967 to the State Department of Health and Social Services, and the number for 1968—when the final reports are completed—is sure to go over the 300 mark, he added.

To overcome the reluctance of people to report their suspicions the Wisconsin Legislature has exempted those required to report from any liability that could arise in mistaken cases. It is imperative, Doctor Jorris said, that these cases be reported so that protection for the child and help for the emotionally disturbed abusers can be provided.

DR. STEFFEN HEADS RACINE SOCIETY

Dr. Elizabeth A. Steffen* of Racine was installed Dec. 10 as president of the Racine County Medical Society. President-elect is Dr. C. W. Christenson* of Racine; secretary, Dr. William C. Harris,* Racine; and treasurer, Dr. Marvin W. Nelson,* Racine. Dr. Beatrice Jones, who died in 1966, was the only other woman to serve as president of the medical society.

FOND DU LAC COUNTY MEDICAL SOCIETY CENTENNIAL PROGRAM—A centennial dinner and Christmas party in December climaxed a year of special events for the Fond du Lac County Medical Society. Several members of the Society were honored for long and dedicated service to medicine and were presented mementoes. Some are shown above, left to right: Dr. L. A. Hoffmann,* Campbellsport, a 49-year member of the Society; Dr. C. W. Leonard,* a 66-year member; Dr. H. R. Sharpe, Sr.,* a 46-year member; Dr. W. E. Myers,* Society president; and Dr. H. J. Kief,* immediate past president of the State Medical Society; all of Fond du Lac. Others honored, but unable to be present, were: Dr. W. J. Waldschmidt,* a 56-year member, and Dr. K. K. Borsack,* a 44-year member, both of Fond du Lac.

The Fond du Lac County Medical Society was formed in 1868 in the office of Dr. William Wiley of Fond du Lac. It followed three earlier societies, the first of which was formed in 1844 and covered about a three-county area. A second was formed in 1854 but left only its constitution and bylaws as a permanent record. The third, organized at Waupun in 1866, took in parts of Green Lake, Dodge, and Fond du Lac counties and lasted only about one year. (Photo courtesy Fond du Lac Commonwealth Reporter)

Dr. Springer to Help Poor in Mississippi

A desire for public service again has taken Dr. Joseph P. Springer* of Durand out of Wisconsin. This time to an economically depressed area of northern Mississippi.

Twice before he has left his practice for brief periods to serve in medically deprived areas. In 1965 he served aboard the hospital ship, SS HOPE, when it was docked at Guinea, East Africa. A two-month tour of volunteer duty in a civilian hospital in Vietnam was made in 1966 under auspices of the AMA.

Doctor Springer left in mid-February to accept a position as an assistant professor in a Tufts University project to Mound Bayou, Miss., a small Negro community where the average family income is $900 a year.

The Boston, Mass., university selected the area as a good place for a pilot clinic. A new building was erected for five doctors and an older building was rejuvenated for a hospital. Eventually, the university hopes to attract Negro doctors to the area so it can phase white doctors into other programs.

Doctor Springer's family will be joining him in June at the close of the school year. The Springers have lived in Durand since 1957 when they moved from Tampa, Fla. Doctor Springer is a graduate of the University of Wisconsin Medical School.

COUNTY SOCIETIES HELP MED TECHS

In late 1968, the Racine and Kenosha county medical societies cooperated with the Wisconsin Association of Medical Technologists in presenting a program to introduce high school and college students to the field of medical technology.

The program consisted of a film showing with a question and answer period for one day and then several hospital laboratory tours were conducted during the rest of the week.

Dr. William Maurer

. . . who recently was discharged from the United States Army Medical Corps, has joined the Marshfield Clinic staff. He is a 1961 graduate of Marquette University School of Medicine, interned at Columbia Hospital, Milwaukee, and took residency training at Columbia Hospital and Veterans Administration Hospital, Madison.

Dr. Robert R. Schwaegler*

. . . of Beloit is teaching a seven-week course for women on "Science and Society: Where Are We Headed?"

Dr. Elizabeth Baldwin

. . . former Marshfield physician, has been named assistant director of the Hendry County (Fla.) Health Department, a position once held by her husband, the late Dr. Robert S. Baldwin.

Dr. Jacob N. Shanberge

. . . has been named director of pathology at Mount Sinai Hospital in Milwaukee. He succeeds Dr. Norbert Enzer* who has retired as director but will continue to maintain a laboratory at the hospital. Doctor Shanberge was associate pathologist and director of hematology and blood banking at Evanston (Ill.) hospital. He is continuing his affiliation with Northwestern University Medical School of Chicago where he is an associate professor of pathology and of medicine.

Dr. Armand J. Quick*

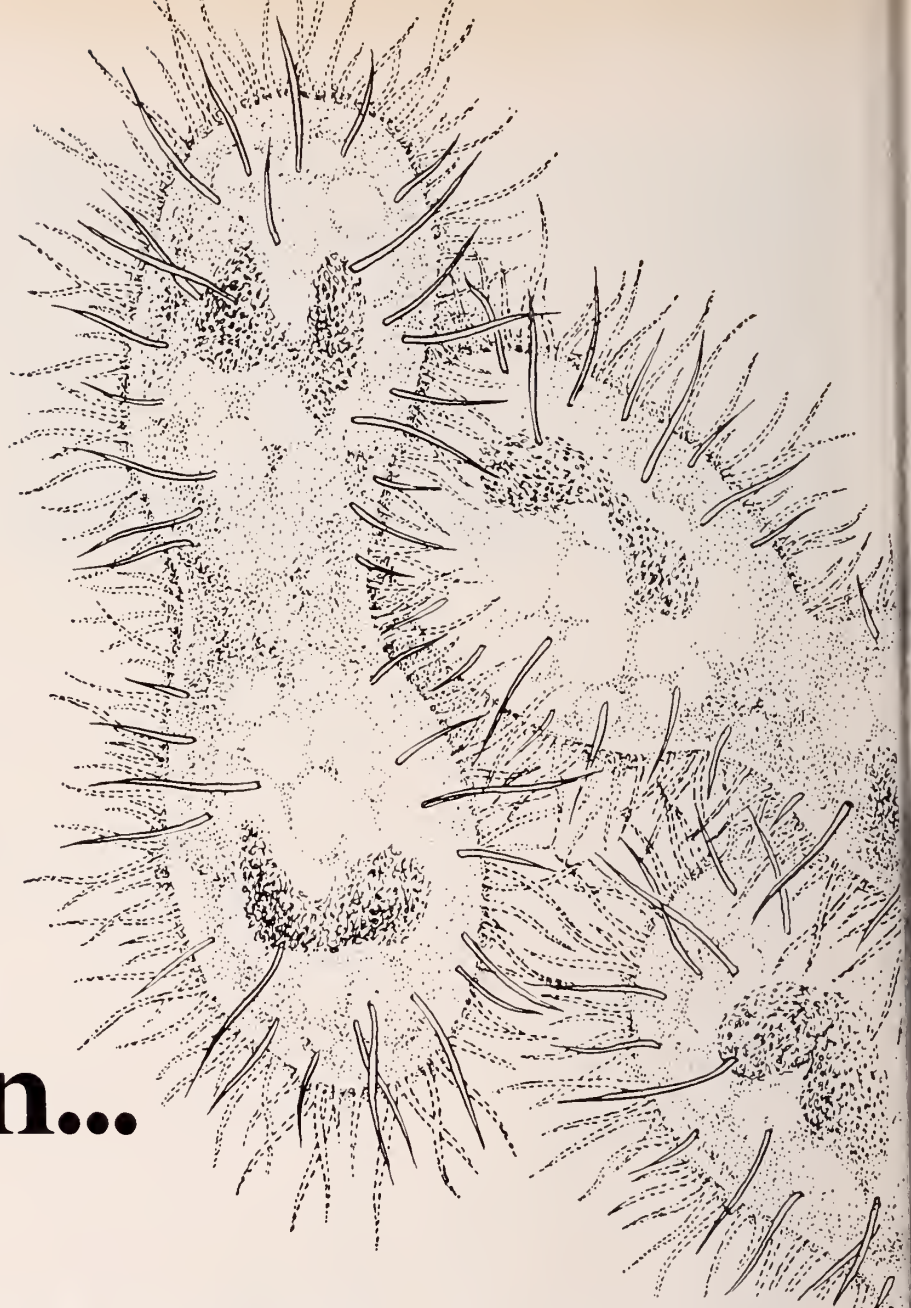
. . . has been reappointed a member of the Subcommittee on Hematopoietic and Lymphatic Systems of the Committee on Rating of Mental and Physical Impairment.

Dr. Francis M. Forster*

. . . Madison, has been reappointed a member of the AMA's Committee on Rehabilitation.

Dr. Robert W. Boyle*

. . . Milwaukee, has been reappointed an alternate to the AMA's Interspecialty Committee representing the American Academy of Physical Medicine and Rehabilitation.



A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

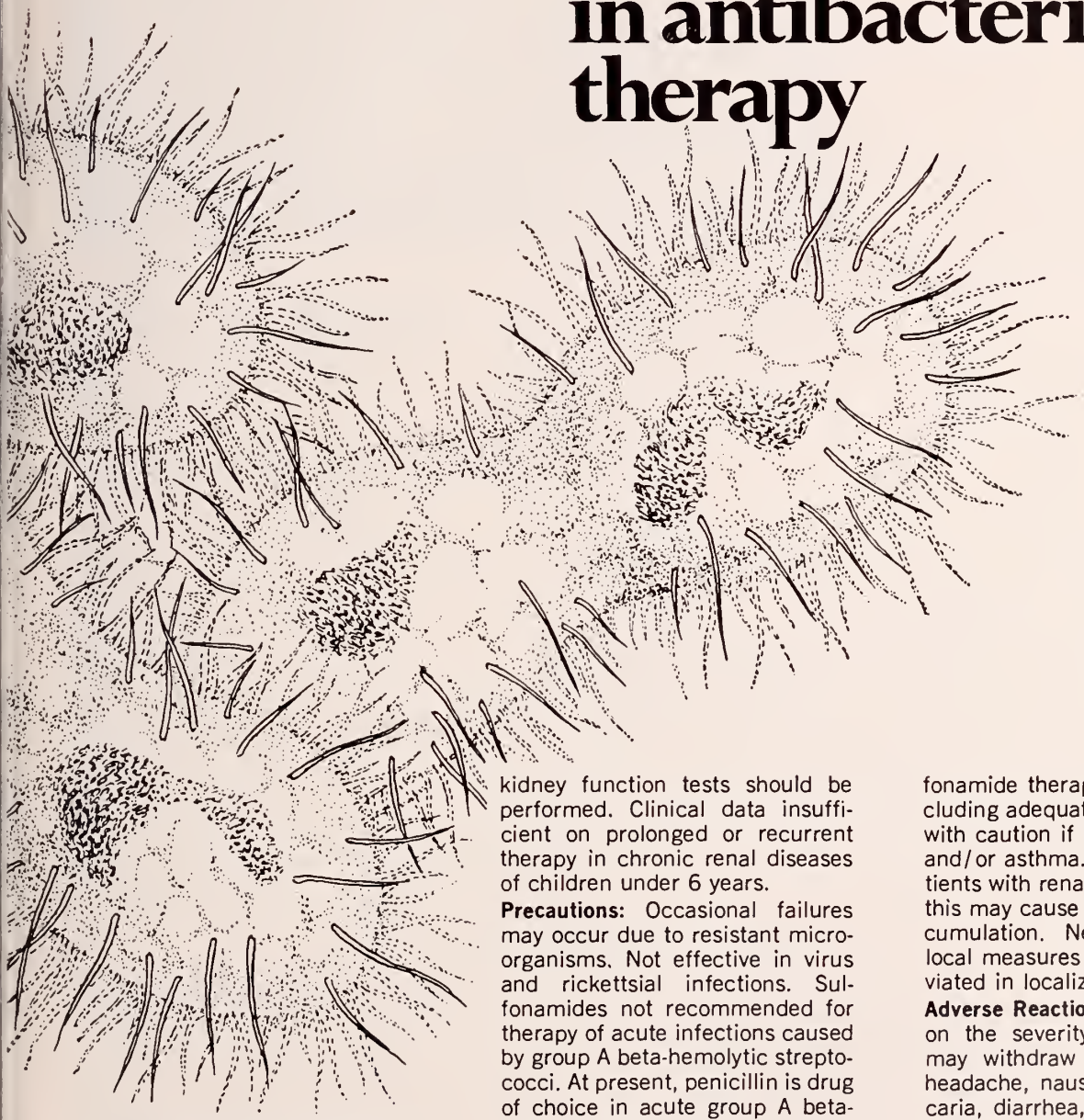
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for* fonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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Dr. Richard D. Stewart*

. . . chairman of the Department of Environmental Medicine at Marquette medical school, will direct a study to measure the behavorial and physiological responses of humans to low concentrations of carbon monoxide.

Financial support for the major portion of the study is from the Coordinating Research Council of New York City under a one year contract for $124,083.

Doctor Stewart is well known for his work in industrial toxicology and has done earlier studies on carbon monoxide poisoning.

Co-investigators on the project are Edward Baretta, environmental engineer and project leader, Michael J. Hosko, PhD, a neuropharmacologist, and Jack E. Peterson, PhD, assistant professor of environmental engineering.

These studies will be carried out at the Allen–Bradley Medical Science Laboratory of the medical school.

Dr. Beverly A. Myers

. . . instructor in pediatrics at Marquette School of Medicine, has been appointed medical coordinator of the Kiwanis Children's Center of the Curative Workshop in Milwaukee. The center, supported largely by the United Fund, provides services for physically and mentally handicapped children, including those with cerebral palsy, arthritis, speech disorders, and others.

For the past two years Doctor Myers has served as an instructor and fellow in pediatrics and psychiatry at Strong Memorial Hospital, Rochester, N. Y. She received her medical training at McGill University, and the Montreal Children's Hospital, Canada.

Dr. E. O. Lukasek*

. . . Sparta, was the featured speaker at an alcohol education workshop in Hawaii. Doctor Lukasek had been invited to participate as first vice-president of the West Central Wisconsin Council on Alcoholism and as a member of the Wisconsin Legislative Task Force on Alcoholism. He spoke on the "History of Alcohol and Alcoholism."

Mental Retardation Grant Approved, UW

University of Wisconsin officials reported Jan. 14 that a federal grant of $2,616,783 for a new Center on Mental Retardation on the Madison campus had been approved in Washington.

Announced by Rep. Melvin Laird (R-Wis.), the U. S. Public Health Service grant augmented by other federal and state allocations, completes the funding of the $7 million facility.

Upon completion in 1971, the eight-story structure will provide facilities for research and professional training in the education, diagnosis, and rehabilitation of the retarded.

The center's program, coordinated by its director, Prof. Rick F. Heber, is expected to focus on the interdisciplinary approach to the problems of retardation and related aspects of human development. Biomedical research in the areas of neurophysiology, neuroendocrinology, and neurometabolism will function under the guidance of Prof. Clinton N. Woolsey, Dr. Thomas C. Meyer,* and Dr. Harry A. Waisman. The research program in the behavioral and social sciences will be coordinated by Prof. Leonard E. Ross.

Doctor Heber paid tribute to Representative Laird, saying:

"He has worked ceaselessly to make this possible for Wisconsin. All of us owe a deep debt to Representative Laird for the great effort he has made to assist in legislation and appropriation of this sum."

In February, 1965, the UW was selected as one of two schools in the country to establish new centers on mental retardation. To get the project underway, the Vocational Rehabilitation Administration provided $192,000. The other school selected is the University of Texas.

The new center, to be located in the area north of the Veterans Administration Hospital and south of Marsh Lane in Madison, is expected eventually to serve 25 states. It will train social workers, teachers, vocational rehabilitation counselors, staff members of shelter workshops, and others in this field.

It will conduct conferences and seminars involving personnel engaged in medicine, social work, psychiatry, nursing, counseling, psychology, and related areas, from all parts of the U.S.A. It will foster fellowship programs in these areas, to give pre- and postdoctoral scholars a year of specialized practical training.

The educational program of the school and the instructional materials center will be the responsibility of Prof. James J. McCarthy, while Dr. Jack C. Westman* will direct the clinical services of the diagnostic and treatment unit.

DR. ROGER CANTWELL OUTSTANDING CITIZEN

A Shawano physician for 47 years was honored as the city's Outstanding Citizen for 1968. The award was presented to Dr. Roger C. Cantwell* during a Chamber of Commerce dinner in December.

Doctor Cantwell graduated from Rush Medical College in 1920, interned and took residency training at Washington Blvd. Hospital, Chicago.

He returned to Shawano in 1922 to enter practice with his father. In 1932, he established the Cantwell–Peterson Clinic with this brother, Dr. Arthur A. Cantwell,* and Dr. Lyndle W. Peterson.*

Doctor Cantwell is a past president of the Shawano County Medical Society and was chairman of the Committee on Cancer and a member of the Division on Aging of the State Medical Society.

DR. COHEN, EDGERTON, HEADS ROCK SOCIETY

Newly elected officers of the Rock County Medical Society for 1969 are: Dr. David A. Cohen,* Edgerton, president, and Dr. Lars W. Kleppe,* Beloit, vice-president. Dr. R. S. Overton,* Janesville, secretary-treasurer, was reelected.

OUTAGAMIE COUNTY MEDICAL SOCIETY—At the December meeting newly elected officers had the pleasure of presenting a plaque to Dr. Ralph V. Landis* (second from left) honoring him for his recreational programs over the years. On the left is Dr. Frank Wright, Jr.,* president, and second from right, Dr. George J. Petersen,* vice-president. Missing is Dr. William H. Hale,* secretary–treasurer. Dr. John H. Russell* (right) is outgoing president. All are from Appleton. (Photo courtesy Appleton Post–Crescent)

First Data Acquisition Machine Installed

Milwaukee's first electronic electrocardiogram data acquisition machine has been installed at St. Francis Hospital.

Dr. Julius M. Meyer,* chief of internal medicine and a member of the Coronary Care Medical Committee, said the data acquisition machine, "Patientransmitter," will take electrocardiogram tracings at the patient's bedside and record them on magnetic tapes for indefinite preservation.

Acquiring the transmitter is the first step toward a totally computerized electrocardiogram system. It eventually will be connected by telephone lines to a centrally located digital computer which will aid physicians in diagnosis through comparison with thousands of other electrocardiograms.

Tracings will be preserved and easily retrievable for future reference —important in follow-up of heart disease. Furthermore, all leads can be taken in about 10 seconds, a saving of several minutes for each electrocardiogram.

While the transmitter will be used in every area of the hospital, it will be of great service to the hospital's new Coronary Care Unit, to be opened soon.

Sister M. Paschalisa, administrator, announced that the St. Francis Guild has contributed $20,000, or about one-third of the Coronary Care Unit cost.

The St. Francis Hospital Foundation is accepting earmarked gifts for the remainder of the total cost of the Unit. About $40,000 is needed, she said.

OCONTO SOCIETY HAS SEX EDUCATION FILM

In an eflort to promote a lasting sex education program in the Oconto county schools, the Oconto County Medical Society through the efforts of Dr. Kenneth L. Strebe,* Oconto Falls general practitioner, recently purchased a film on the subject. The film also is available for showing to any civic group in the county.

Dr. George Gutmann*

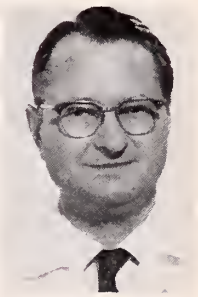
. . . Janesville internist, was a guest speaker at a symposium of nurses Jan. 21 at South Beloit, Ill. He described causes and prevention of stroke.

Dr. Brian J. King

. . . has joined the Midelfort Clinic, Eau Claire, in the Department of Surgery. Born in London, England, he completed his surgical training at the London Hospital and took his medical degree at Cambridge in 1957 and graduated MA from Cambridge in 1958. Internship was spent at the University of Oxford. In 1959 he assumed a fellowship in general surgery at the Mayo Clinic in Rochester, Minn., where he remained until 1964 when he began practicing in Oregon.

Dr. Werner Langheim*

. . . has opened an office for the practice of neurological surgery in the Madison Medical Center at the corner of Regent and Park streets in Madison. After his training in Germany and the Mayo Clinic, Doctor Langheim came to the University of Wisconsin Medical School, Madison. He advanced to clinical assistant professor of surgery, division of neurological surgery, and has been chief of neurological surgery at the Veterans Administration Hospital, Madison, since 1964. He is a diplomate of the American Board of Neurological Surgery.



Werner Langheim, MD

Kenosha Society

. . . president, Dr. Michael J. Bode* of Kenosha, recently met with police and fire chiefs, the sheriff, and representatives of Memorial and St. Catherine's hospitals to establish a set of rules for the fastest, safest possible transportation of emergency patients.

Dr. Roman E. Galasinski*

. . . and two other physicians from Illinois and Missouri, formed a team in the Miami Medical Bowl Quiz, a show which was viewed over television three days during the AMA clinical session in Miami, Fla., early in December. The program was aimed at promoting the AMA meeting and dealt with medicine as it related to the political and economic aspects. The program as it was taped had Doctor Galasinski's team as the loser by 10 points; however, as Doctor Galasinski and his teammates viewed it live it appeared to them that their team had won by 20 points. But as Doctor Galasinski jested in retrospect, "So, you can't win 'em all." The program was entertaining as well as interesting and one which the participants enjoyed and will remember for some time. Doctor Galasinski is a surgeon practicing in Milwaukee and is a delegate of the State Medical Society to the AMA House of Delegates.

Dr. Victor S. Falk*

. . . recently was named a member of the Advisory Committee of the State Medical Journal Advertising Bureau to fill the unexpired term of Dr. Thad Moseley who retired as editor of the FLORIDA STATE MEDICAL JOURNAL last June. His term runs until Dec. 31, 1969. The committee reviews advertising commitments of the Bureau which handles advertising for most state medical journals in the United States, including the WISCONSIN MEDICAL JOURNAL. Doctor Falk is the medical editor of the WMJ.

Dr. Anthony V. Pisciotta*

. . . has been reappointed a member of the AMA's Subcommittee on Hematopoietic and Lymphatic Systems of the Committee on Rating of Mental and Physical Impairment.

Washington Society

. . . cooperated with the WEST BEND NEWS in December to alert the public to the dangers of drug abuse. The paper published an all-inclusive article on the subject.

WPS Offers Senior Citizen Plan

Wisconsin Blue Shield (WPS) is offering a special open enrollment from Jan. 1 through Mar. 31, 1969, for its major medical contract for senior citizens. The contract, called Medicare-PLUS $15,000, will pay up to $15,000 to fill gaps and extend benefits offered by Federal Medicare.

This contract was one of the first of this type offered in Wisconsin.

Anyone 65 or over can apply in the open enrollment. No health examination is required. Benefits for preexisting conditions are covered after the first six months, if such conditions are not treated during the first six months following the effective date.

For those already covered by Medicare-PLUS $15,000, coverage will be effective on the first of the month following the date of application. For those enrolling in both Medicare-Part B and Medicare-PLUS $15,000, coverage will be effective on July 1, 1969.

The premium for the Medicare-PLUS $15,000 contract is $9.50 per month.

The Medicare-PLUS $15,000 contract offers the following advantages:

. . . $15,000 benefit for each insured illness and each insured injury for a 4-year benefit period. It extends benefits offered by Federal Medicare Hospital and Medical Plan Part A and B.

. . . Full payment up to contract maximums for covered expenses when Federal Medicare benefits are exhausted.

. . . Deductibles and coinsurance under the Federal Medicare Program are payable. The only exclusions are those expenses actually paid or payable under the Federal Medicare and items or services excluded from Federal Medicare coverage.

. . . There is a $50 annual deductible, which is refunded when covered expenses exceed $50. Out-of-pocket expenses paid under the Federal Medicare Program apply to this deductible.

. . . Policy is guaranteed renewable for life . . rates may be changed only if rates of all members of the subscriber class are changed.

. . . Hospital and nursing home days are unlimited, as are drugs recommended by a physician (including self-administered), in-hospital private duty nurse, and doctor's home and office calls.

. . . There is a 365-day lifetime benefit for inpatient psychiatric hospital care. Medical care for mental, psychoneurotic and personality disorders is paid up to 50% or $1,000, whichever is lesser.

. . . Benefits are paid in addition to policies payable from other insurers.

WPS home offices are at the State Medical Society headquarters in Madison, Wisconsin, 330 East Lakeside Street. Further information on the WPS Medicare-PLUS $15,000 contract may be obtained by writing to Box 1109 at that address, or phone (608) 257–6781.

NURSE TRAINING GRANT TO WISCONSIN SCHOOL

The Division of Nursing, a division of the Bureau of Health Manpower, National Institutes of Health, has announced a matching grant for the construction of nursing education facilities at Wisconsin State University–Oshkosh. The grant, as authorized by the Nurse Training Act, is $550,319. The construction project will enable the establishment of a baccalaureate degree nursing education program with places for 60 first-year students.

IN-DEPTH PROGRAM

Female Hormones at Age 50 will be subject of In-depth program at UW Medical Center and State Medical Society in Madison, Mar. 13.

COMMITTEE ON THE HISTORY OF NURSING IN WISCONSIN—This subcommittee of the Wisconsin Nurses Association met Dec. 12 at the State Medical Society headquarters in Madison for preliminary planning of a new nursing exhibit for the Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien. Attending were those shown above, left to right: Mrs. Thelma Burkee, TB nursing consultant (retired), State Division of Mental Hygiene; Miss Ella T. Newmann, administrator (retired), Sunnyrest Sanatorium, Racine; Mrs. Agnes Jensen, TB nursing consultant (retired), State Division of Health; Miss Iva Louise Hartman, administrator (retired), Pinehurst Sanatorium, Janesville; and Miss Josephine Balaty, educational consultant, State Division of Nurses.

IONE ROWLEY RETIRES

A nurse administrator, well known to physicians and organized medicine, retired as chief of public health nursing in the State Department of Health and Social Services at the end of 1968.

Miss Ione Rowley, who has seen many of the dread diseases of the past brought under control, had worked 31 years in the State Division of Health. Although she has retired, Miss Rowley plans to remain in Madison and continue to work for improvements in public health nursing, a field she hopes more girls will consider when choosing a career.

DOCTOR GROUP WILL AID SUSSEX AREA

Medical Associates, a group of 11 physicians located in Menomonee Falls, opened a branch office in Sussex Jan. 13. The physicians are located in the office formerly used by Dr. Erwin VanValin, who had practiced in the Sussex area for 31 years prior to his death.

Medical Associates will have office hours by appointment Mondays through Fridays from 1 to 5 p.m. with a receptionist on duty at the office after 12 noon. Since this is a branch office, all business matters or phone calls are being transacted through the Menomonee Falls office.

Physicians presently associated with the Medical Associates are: Drs. R. H. Bibler* and H. D. Drayer,* pediatricians; Drs. W. M. Brennan,* P. J. Dougherty,* H. A. Kneubuhler,* and J. R. Hoffman,* internists; Drs. T. A. Hofbauer* and R. D. Schmidt,* obstetricians and gynecologists; Drs. J. J. Foley* and J. D. Riesch,* general surgeons. Dr. Robert Dawes,* thoracic and cardiovascular surgeon, is presently serving his tour of duty in the U. S. Army in Vietnam.

AMA MEETING JULY 13–17

Total registration of 60,000 is predicted for the 1969 annual convention of the American Medical Association in New York City July 13 through 17.

Brown Society

. . . at its October meeting voted approval to a program initiated by the Wisconsin Heart Association for the purpose of training instructors, disseminating information, and setting up formal instructions for cardiopulmonary resuscitation techniques. The program will be supervised by physicians of the WHA and by local physicians.

Following discussion of a letter from a high school principal in which he stated that several of the area high schools have had difficulty arranging doctor coverage at their home football games, the Society reaffirmed its position that this coverage remains the responsibility of the officials of the individual high school, but the Society did encourage its members to cooperate with the school officials on a voluntary basis in so far as possible.

Dr. George Nadeau,* district representative of PACE (Professional Association for Civic Education), outlined the need for physicians, as citizens of this country and this community, to be politically aware. He cited the legal aspects of political activity and then explained the rights of physicians as individuals.

Following the business session Dr. Samuel R. McCreadie* of the Department of Pathology, Milwaukee Children's Hospital, spoke on "Sudden Death in Infants and Children."

Milwaukee Academy of Medicine

. . . held its 83rd annual meeting Jan. 21 at the University Club of Milwaukee. The following new officers were installed for 1969: president, Dr. Bruno J. Peters;* president-elect, Dr. Robert W. Byrne;* vice-president, Dr. Paul G. LaBissoniere;* secretary, Dr. Wayne J. Boulanger;* treasurer, Dr. Donald P. Babbitt;* librarian, Dr. Richard D. Fritz;* and chairman of the membership committee, Dr. Gerson C. Bernhard.*

Col. Clyde H. Kratochvil, USAF, MC, presented the guest lecture, "The Use of Non-human Primates in Medical Research." He is with the Aeromedical Research Laboratory, Wright–Patterson Air Force Base.

Dr. Marek J. Hann

. . . Warsaw, Poland, joined the staff of the Columbia county guidance health center as a staff psychiatrist. Doctor Hann, a fellow in child psychiatry at the department of psychiatry, University of Wisconsin Medical Center, Madison, completed his training as an adult psychiatrist. He received his doctorate in medicine at the Academy of Medicine in 1963 and interned at the postgraduate medical school in Wausau. He took his three-year residency training in psychiatry at the University of Wisconsin.

Dr. Robert E. Hassler*

. . . Monroe, has been named fellow-elect in the American College of Obstetrics and Gynecology. He is a diplomate of the American Board of Obstetrics and Gynecology and has been a member of The Monroe Clinic staff since 1967.

Dr. Karl L. Siebecker*

. . . professor in anesthesiology at the University of Wisconsin Medical Center, Madison, attended the first annual meeting of the Society of Academic Anesthesia Chairmen held in Chicago last November.

Dr. Edward A. Zupanc*

. . . Monroe, was selected by the American Academy of Pediatrics to serve as a Head Start consultant in Wisconsin. Doctor Zupanc is the Monroe City Health Officer and chief-of-staff and head of the Department of Pediatrics at St. Clare Hospital. He is a clinical instructor in the department of pediatrics at the UW Medical School and chairman of the executive committee of The Monroe Clinic.

Dr. E. Howard Theis*

. . . Fond du Lac, recently was certified as a diplomate of the American Board of Obstetrics and Gynecology.

Dr. Richard Van Dreel*

. . . Manitowoc Clinic pediatrician, passed his examination at Chicago to complete his qualifications for board certification by the American Academy of Pediatrics.

Cancer Research Grants Awarded Milwaukee Men

Five cancer research grants totaling $37,459 were awarded to Milwaukee scientists by the Milwaukee Division of the American Cancer Society, it was announced recently by Dr. L. J. Van Hecke,* division president.

The grants went to Dr. Mortimer M. Bortin,* associate professor of clinical medicine, Mount Sinai Hospital, $6,707, and to the following members of the Marquette Medical school:

Dr. Gary A. Becker, assistant professor of medicine, $9,000; Dr. H. M. Kauffman,* assistant professor of surgery, $12,652; Dr. George A. Marzluf, assistant professor of biology, $1,600, and Dr. Richard I. H. Wang,* associate professor of pharmacology and medicine, $7,500.

Doctor Van Hecke pointed out that the grants were approved by the cancer society's medical and scientific committee of which Dr. James E. Conley* is chairman.

STATEWIDE TEACHING BY TELEPHONE–RADIO

Some 40 hospitals in Wisconsin are participating in a series of eight statewide telephone–radio teaching conferences entitled, "Interaction of Allied Health Professionals in Rehabilitation."

The complete series involves one program a month for eight months and deals basically with the multidisciplinary approach to rehabilitation.

The conference is being sponsored by the University of Wisconsin, the University Extension and Medical Center, and the Department of Postgraduate Medical Education.

Participants, who have preregistered for the course, gather at hospitals throughout the state to hear the program over either radio or telephone.

Each teaching station has been equipped with a loudspeaker to amplify the incoming program and a slide projector to show visual aids. Each program runs an hour and a half.

Programing began last October and will continue through May.

Alcohol Involvement High, Driver Deaths

Figures released Jan. 22 by the State Division of Health on blood tests from 33 motor vehicle drivers killed in November 1968, show that alcohol was involved in 23 with 11 at or above the legal intoxication level. For 11 months of 1968, January through November, the Division's blood testing program showed alcohol involvement in 256 out of 392 driver deaths reported, with 130 at or above the legal intoxication level of 0.15 percent.

The report also revealed the heavy involvement of alcohol in pedestrian deaths. Five out of five blood sample tests on pedestrians killed in November showed alcohol, three of them at or above the legal intoxication level. For 1968 through November, alcohol was involved in 39 of 56 blood tests on pedestrian fatalities, with 18 at or above the 0.15 percent level.

State law requires blood samples to be tested for alcohol content on motor vehicle drivers and pedestrians, age 16 and over, who die within six hours of their accident.

WISCONSIN SCOREBOARD

DRINKING • DRIVING • DEATH

MOTOR VEHICLE DRIVER DEATHS REPORTED, 1968

DEATHS	NOVEMBER	JAN. thru NOV.
Total Deaths Reported	33	392
No. With Alcohol Involved	23	256
Percent	69.7	65.3
No. With Alcohol at or Above .15% (Legal Intoxication Level)	11	130
Percent	33.3	33.2

Compiled by the State Division of Health

Dr. R. B. Pittelkow President-elect Milwaukee Society

Dr. Robert B. Pittelkow,* Milwaukee, was elected president-elect for 1970 at the Dec. 12 annual meeting of The Medical Society of Milwaukee County. The annual session also commemorated the 25th anniversary of Surgical Care–Blue Shield, the insurance division of the county society.

R. B. Pittelkow, MD

Dr. Howard L. Correll,* Milwaukee, is the new president succeeding Dr. George E. Collentine, Jr.,* Milwaukee, who was elected to a post on the Board of Directors.

Dr. Leonard W. Worman* and Dr. Benjamin G. Narodick* were elected secretary and treasurer respectively.

Doctor Pittelkow is a graduate of Marquette University School of Medicine where he is an assistant professor of dermatology.

BIOMEDICAL COMPUTER CENTER OPENS

Marquette School of Medicine opened its new Biomedical Computer Center Dec. 18. The center, 1725 West Wisconsin Avenue, Milwaukee, occupies the first floor of a building which was recently given to the medical school as a gift from Abner E. Kops of Milwaukee, its former owner. The building also houses offices for the school's division of preventive medicine.

The center is a new service facility for the medical school and will be used for its scientific, teaching, and business activities. An IBM 360, model 40, computer has been installed along with data processing equipment.

Dr. Alfred Rimm, the school's biostatistician, foresees many uses of the computer in research work. Analysis at any level of sophistication is possible he says. Doctor Rimm will be responsible for acquainting the faculty of the school with computer principles and applications to medical problems. Dr. Sidney Shindell,* preventive medicine chairman, is the center's acting director until a full time director is recruited.

1969 OFFICERS NAMED TRI-COUNTY SOCIETY

The 1969 president for the Ashland–Bayfield–Iron County Medical Society is Dr. Arlyn A. Koeller* of Ashland. Dr. John E. Kreher* of Ashland is the secretary.

At the Society's Nov. 14 meeting Dr. Dominic J. Martinetti of Hurley, who spent three months in Vietnam, showed slides of his trip and commented on his duties at the civilian hospital.

CHARLES LEMKE NAMED WRMP EVALUATOR

Charles W. Lemke of Verona has been named evaluations coordinator for the Wisconsin Regional Medical Program.

Charles Lemke

Mr. Lemke was formerly chief of the Section of Research, State Division of Health.

In the newly created position, Mr. Lemke will be responsible for providing an evaluation procedure for all projects of the medical program as well as keeping a report on their progress.

He will be headquartered in Madison.

HEALTH CAREER GUIDE

Information on 26 careers in health is contained in a brochure published by the Wisconsin Health Council and available from the SMS, Box 1109, Madison, Wis. 53701.

Waukesha Society

. . . is cooperating with the University of Wisconsin Extension Division in presenting a series of clinics on "Drug and Narcotics Abuse."

Dr. Richard T. Flynn, Jr.*

. . . recently opened his office in East Troy. Doctor Flynn, who was formerly director of Physical Medicine and Rehabilitation at St. Mary's Hospital, Milwaukee, is a graduate of the Marquette School of Medicine and interned at St. Vincent's Hospital, Portland, Ore. His son, Richard III, is a trained surgical and physical medicine technician and will be associated with him in his general practice.

Dr. Horace K. Tenney III*

. . . University Hospitals, Madison, has been named chairman of the American Academy of Pediatrics Head Start Medical Consultants Service for Wisconsin. Doctor Tenney is medical director of the State Bureau for Handicapped Children.

Dr. Allan J. Ryan*

. . . Madison, has been reappointed chairman and member of the AMA's Committee on Exercise and Physical Fitness.

Dr. Henry A. Peters*

. . . of the University of Wisconsin Medical School was a speaker at the mid-winter conference of the Wisconsin District Attorneys Association in Milwaukee Jan. 22–24. Panel discussions on narcotics and the dangerous drug problem highlighted the conference.

Walworth Society

. . . met Nov. 21 at Lake Geneva with 18 members present. P. C. Chadha, BDS, MDS, of the Marquette University School of Dentistry, Milwaukee, addressed the Society on the subject, "Fractures of the Jaw."

Dr. John R. Guy*

. . . Waukesha physician, announced his retirement from the county health board effective Jan. 1, 1969. He had been on the board for six years.

Help the Needy!

This patient may appear to "have everything" but, like so many people getting along in years, she may well be in need—*medically*. Though there is no evidence of organic disease, she does have symptoms (fatigue, vague aches and pains, malaise) that may be indicative of—

a need to maintain anabolic balance... to counteract declining gonadal hormone secretion and forestall premature degenerative changes related to estrogen deficiency;

a need for mood elevation... to impart a gentle emotional uplift;

a need for nutritional supplementation... to compensate for the poor eating habits and subsequent dietary insufficiency of so many older people.

For these needs, consider MEDIATRIC for your next "needy" patient... medically.

MEDIATRIC provides specific agents to fulfill a need in the three areas:

1. **Gonadal steroids** [PREMARIN® (conjugated estrogens-equine), an orally active, natural estrogen, and methyltestosterone] for physiologic and metabolic benefits.

2. **Methamphetamine** to provide gentle elevation of mood.

3. **Nutritional supplements** specially selected to meet the requirements of the elderly individual.

Mediatric®

tablets • capsules • liquid

Steroid-nutritional compound

	Each MEDIATRIC® Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC® Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsic.	30.0 mg.	—
Ascorbic acid	100.0 mg.	—
		Contains 15% alcohol† † Some Loss Unavoidable.

Contraindication: Carcinoma of the prostate, due to methyltestosterone component.

Warning: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

Side Effects: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

Suggested Dosages: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

Supplied: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

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Dr. Toedulfo M. Parong*

. . . a native of the Philippines, has become associated with Dr. C. L. Weston* of New Lisbon. Doctor Parong graduated from Santo Tomas University, Manila, and has spent a year as a volunteer physician in South Vietnam. He was a general practice resident at St. Luke's Hospital, Manila, and came to this country where he served as a rotating intern at St. Elizabeth Hospital, Youngstown, Ohio and Bon Secour's Hospital, Bradford, Pa. He spent three years as a general surgery resident at Good Samaritan Hospital, Dayton, Ohio, and had four years in general practice in the Philippines. Before coming to New Lisbon, Doctor Parong served as a surgical house officer in Suburban Community Hospital, Warrensville Heights, Ohio.

Dr. Thomas M. McCarthy*

. . . Madison, has joined the Quisling Clinic in the specialties of Internal Medicine and Medically Treated Chest Diseases. He received his degree from Marquette University School of Medicine in 1959 and served with the United States Air Force following his internship. Before joining the Quisling Clinic, he was assigned to Wright Patterson Air Force Hospital as chief of Internal Medicine and the Pulmonary Function Laboratory. He is a certified diplomate of the American Board of Internal Medicine and a member of the American College of Physicians.

Dr. Fred W. Fletcher*

. . . cardiologist at the Marshfield Clinic, Marshfield, was elected to fellowship in the American College of Physicians.

Dr. G. Daniel Miller*

. . . Oconomowoc, recently was appointed to the executive committee of the State Board of the American Cancer Society. He is chairman of the public education committee of the Wisconsin Division of the Society, president of the Oconomowoc area branch, and serves on the board of the Waukesha County Unit of the American Cancer Society.

Seeing Under the Cover: Methodist Hospital

On Dec. 4, 1968, Methodist Hospital of Madison held a special dinner and tour of the hospital's new addition. Physicians throughout Dane County were invited and over 40 were able to attend the dinner and tour.

Not often do doctors get to see below the surface of the gleaming facilities that a new hospital offers them. The physicians were invited to view Methodist Hospital while the addition is still under construction so that they could see what goes into providing the facilities which they will be using when completed.

The tour proved to be not only interesting to the doctors but also extremely valuable to the hospital as well, according to William E. Johnson, Jr., administrator of the hospital. Some additional facilities were suggested by the physicians, and Methodist Hospital was able to incorporate them into the construction plans, he added.

At the end of December one patient wing of the addition had been opened. A second wing was put into service in January and a third in February. The building is scheduled for completion late in the summer.

METHODIST HOSPITAL—Drs. Werner Langheim,* Gordon Tuffli,* and Norman Clausen* take a look at the piping that the walls of the new surgical section at Methodist Hospital will soon cover up.

COMMUNITY-SPONSORED DIABETES PROGRAM

A complete, field-tested and proved how-to-do-it package for running a continuing WHY WAIT? diabetes detection program in a community is available for the asking. The package tells how to organize a diabetes detection program and also provides samples of promotional posters and folders. A community qualifies if:

1. Blood testing techniques are used which are approved by the county medical society.
2. Screening is conducted under the supervision of a physician.
3. Positives are referred to their private physicians for diagnosis and treatment.
4. Records are maintained to obtain results of both testing and physicians' diagnoses.

If the community can fulfill these criteria and is interested, a written request should be made to the Disease Detection Information Bureau, 3553 Peterson Ave., Chicago, Ill. 60645, for the WHY WAIT? Campaign Manual and Promotion Kit.

TALK ON WISCONSIN WORK WEEK OF HEALTH

Three Marinette high school students—William Ames, Pamela Kushman, and Marion Kortbein—on Jan. 7 gave their impressions of the 1968 Wisconsin Work Week of Health, which they attended in Madison last October, at a program in the library of the school. The audience included the auxiliaries of the Marinette County Medical Society and Marinette Dental Society, the Tri-City Area Clergy Council, and the high school faculty.

At a health careers program in January sponsored by the Woman's Auxiliary to the Brown County Medical Society, junior and senior high school students at Green Bay viewed a series of films taken from the 1968 Work Week of Health program.

SMS ANNUAL MEETING

Mark your calendar: May 12–15 in Milwaukee.

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

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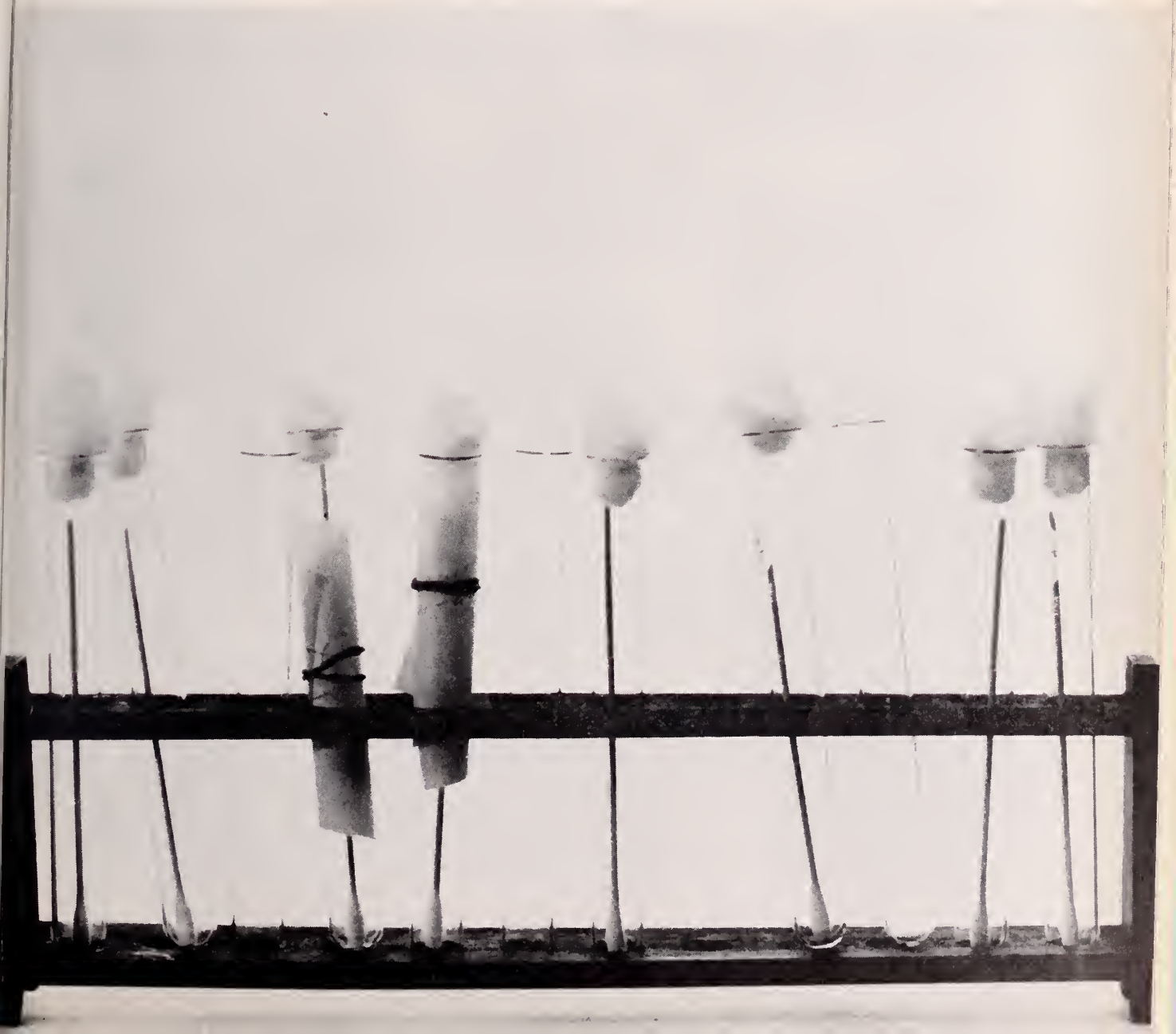
The price differential is inconsequential.



Alcoholism

. . . and its related problems, as they affect the lives of men and women in the Neenah–Menasha community, will now be handled by the newly organized information and referral center known as Alcoholism Services of Neenah–Menasha. The center's services were explained to more than 200 industry executives, agency workers, law enforcement officers, judges, and the medical and health professions at a gathering in December. Dr. John L. Norris, medical director of Eastman Kodak, Rochester, N. Y., and a nationally recognized authority on alcoholism identification and treatment, was guest speaker. The center's executive director is Pat Kelly.

Warren H. Southworth, PhD

. . . professor of health education at the University of Wisconsin, recently received the William A. Howe Award at the annual meeting of the American Public Health Association in Detroit. Doctor Southworth was selected by nomination from the general membership for "demonstrated leadership and devotion to the promotion of health and health education of our school children."

Dr. Walter P. Stenborg*

. . . Elm Grove, was recently named president of the Milwaukee Gastroenterological Society. Dr. Michael A. Polacek,* Wauwatosa, is vice-president, and Dr. Daniel H. Winship, Brookfield, secretary–treasurer.

Dr. R. L. Hendrickson*

. . . Cornell, was host to the Chippewa County Medical Society Jan. 7 at Roberts Steak House. A movie entitled, "Cold Endoscopy," was shown.

Dr. F. T. Mansell

. . . recently joined Dr. C. E. Kozarek* at the Kozarek Medical Clinic, Tomah. Doctor Mansell, a native of Cincinnati, Ohio, graduated from the University of Cincinnati Medical School in 1963 and interned in California. He served two years in the United States Air Force and was stationed in Okinawa.

Health Mobile Unit Testing Blood Chemistry

Early detection of 12 chronic diseases from a single blood specimen is now possible under the new screening program of the State Division of Health.

Dr. E. H. Jorris,* state health officer, said in January that the division's mobile units are adding blood chemistry to their regular screening program which already includes chest x-rays and blood pressure tests.

"Twelve blood chemistry tests are performed on serum from each blood specimen collected by the mobile unit," Doctor Jorris said. "Diseases of the heart, liver, kidneys, and bones, gout and certain forms of cancer may thus be detected at an early stage before symptoms appear."

Wisconsin is the first state to bring these blood chemistry tests to its residents through mobile units. Making the program possible is the health division's new computerized autoanalyzer which does separate tests on each specimen at the rate of 60 specimens an hour. To insure accuracy, every tenth specimen is of known blood chemistry and serves as a control.

The state health officer emphasized that the tests are not a substitute for a complete doctor's examination. Because they do provide an indicator for possible hidden chronic disease, results of all abnormal findings are reported to the personal physician for determination of need for further diagnostic studies.

Doctor Jorris said the blood chemistry tests have four principal objectives:

1. To discover chronic disease at the symptom-free state so that medical attention can be given before physical manifestations appear.

2. To establish "normal values" for the tests by age, sex and possibly ethnic group.

3. To encourage the public to establish the habit of taking regular screening examinations.

4. To enable the State Laboratory of Hygiene to provide better consultative services to hospital laboratories in Wisconsin on the use of the equipment and evaluation of the automated blood chemistry determinations.

Two months of field testing preceded the actual start of the blood chemistry program. Nearly 4,000 persons were tested and the results analyzed by the autoanalyzer at the State Laboratory of Hygiene, Madison.

CARDIOLOGY LABORATORY OPENS IN MILWAUKEE

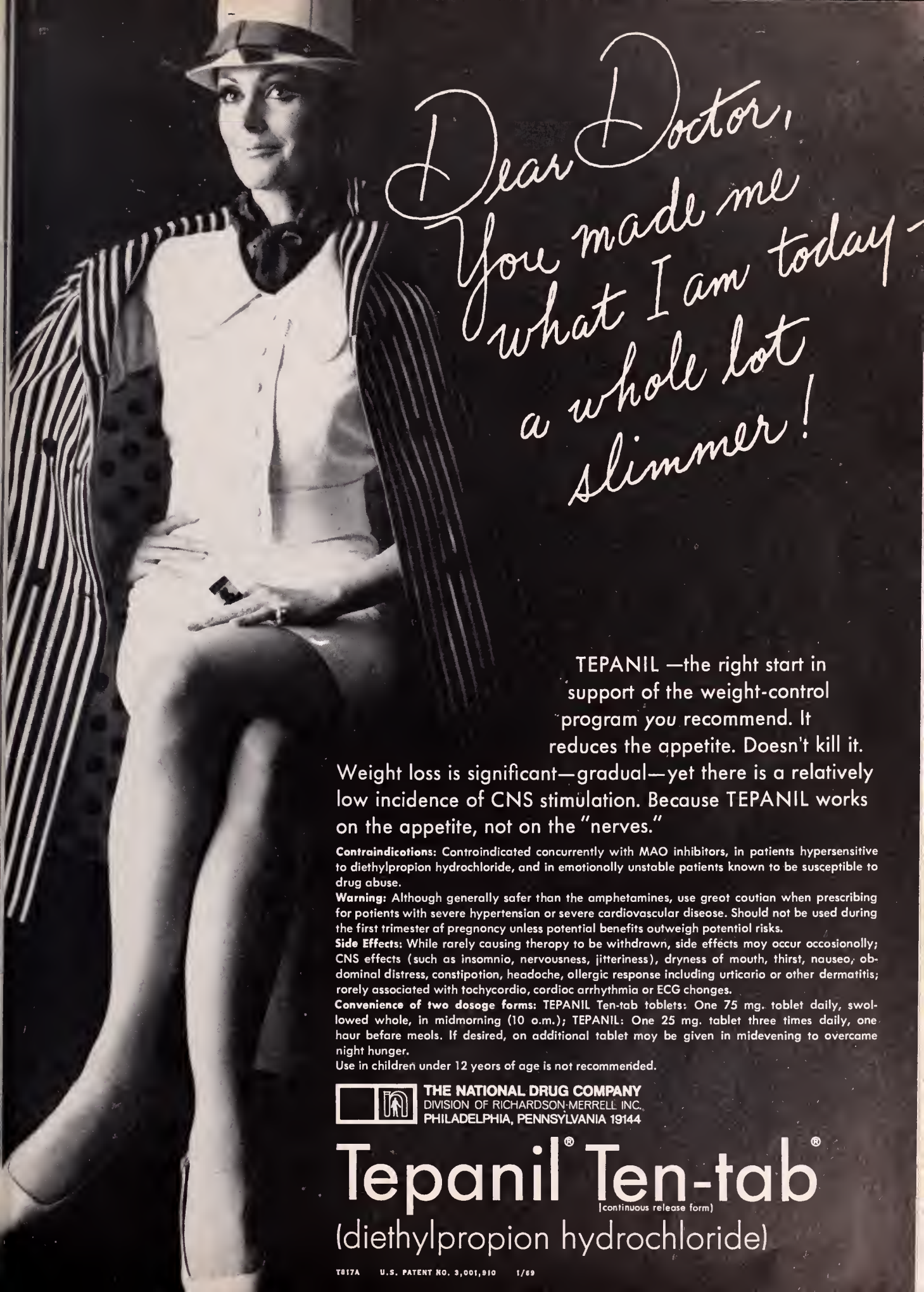
A new laboratory for the diagnosis and study of diseases of the heart and blood vessels was opened last October at Milwaukee County General Hospital. The laboratory is one unit of new, highly specialized intensive care facilities which are nearing completion at county hospital in preparation for the hospital's participation in a medical center for Milwaukee. A coronary care unit also will be part of this complex and will be used in conjunction with the laboratory.

Dr. Ramon L. Lange,* professor of medicine at Marquette School of Medicine and head of cardiology at the hospital, says that the new laboratory will enable the hospital to better care for emergency heart and circulatory crises. It will improve the quality of routine examinations and permit investigative work.

ELECT NEW OFFICERS RICHLAND SOCIETY

Dr. Donald J. Taft* of Richland Center was elected president of the Richland County Medical Society at its December meeting. Other officers are: Dr. George Park, Jr.,* Richland Center, vice-president; and Dr. L. M. Pippin,* Richland Center, secretary–treasurer.

Dr. Richard W. Edwards,* Richland Center, was named delegate to the State Medical Society and Doctor Parke was named alternate delegate. Dr. Jack I. Spear,* Richland Center, was appointed public relations officer.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Dr. W. G. Huibregtse*

. . . began a 60-day tour of volunteer duty in Vietnam, in mid-January. He will be treating civilian patients under the direction of the American government through an arrangement with the AMA's "Volunteer Physicians for Viet Nam" program. Doctor Huibregtse has been practicing in Sheboygan since 1934 and is a veteran of World War II. At the conclusion of his tour, Mrs. Huibregtse will join him in Bangkok to return to the United States via New Delhi, Tehran, Istanbul, and London.

Dr. Thomas J. Beno*

. . . was recipient of St. Norbert College's 1968 Alma Mater Award for vocational success and outstanding service in Christian life. Doctor Beno has been in private practice of surgery in Green Bay since 1954. He is a 1943 graduate of St. Norbert's where he majored in chemistry. He later received his MD degree from the University of Wisconsin. In 1967 he served a 60-day tour of volunteer duty in Vietnam through the AMA's "Volunteer Physicians for Viet Nam" program.

Barron–Sawyer–Washburn–Burnett Society

. . . helped sponsor a program on emergency medical service in the Hayward area late in 1968. Participants outlined and discussed present and proposed state and federal legislation as well as area emergency medical services.

Dr. Raymond S. Koziol

. . . Oostburg, recently opened his office for the practice of general medicine and obstetrics. Doctor Koziol graduated from the Stritch School of Medicine of Loyola University and served his internship at Cook County Hospital, Chicago, and later completed a year of residency training in internal medicine.

Cost of Veterans

. . . Administration medical care for our 26 million veterans was over $1.4 billion in 1968.

CONTRIBUTIONS—CES FOUNDATION
December 1968

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for December 1968.

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CAN CHP VETO HOSPITAL OR CLINIC BUILDING PLANS?

National hospital and medical authorities have drawn attention to a little-noted 1967 amendment of the Partnership for Health act which seemingly puts the state and federal governments in more direct control of capital funding of health facilities.

In a report to the House of Delegates last June, the AMA Council on Medical Service pointed to the following amendment to Public Law 89–749:

> "The State program shall provide for assisting each health care facility in the State to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan developed in accordance with criteria established by the Secretary, which will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner. . . . ."

The AMA Council concluded that the provision "does not appear to abrogate local decisions. It appears designed to ensure that the process of planning at the local level actually occurs."

Others are not so sure. They think it amounts to hospital and clinic franchising.

Less clear is whether this provision has the "teeth" by which the Secretary of HEW could directly or indirectly order the withholding of federal grants, Medicare certification, or medical funds to hospitals which did not comply with this section.

The amendment clearly requires the State comprehensive planning agency to aid all health facilities in their planning for capital expenditures.

AMA concludes that maintenance of the current federal policy of "involvement" rather than "a master plan" is dependent on vigorous voluntary efforts by the profession in local planning agencies.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JANUARY 1969

7 Board of Trustees and New Members, Dane CM Society
7 Surgical Staff, Madison General Hospital
7 Madison Urological Society
7 Madison Anesthesiology Society
9 SMS Division on Ear, Nose, and Throat
12 Central Wisconsin Chapter, National Multiple Sclerosis Society
13 Insurance Advisory Committee, Dane CM Society
13 Utilization Review Plan, Dane CM Society
15 Cardiology Study Committee, Wisconsin Regional Medical Program
16 In-depth Teaching Program, UW and SMS
18 Subcommittee on Postgraduate Education for Obstetrical Nurses, SMS Division on Maternal and Child Welfare
22 Planning Committee, Wisconsin Regional Medical Program
23 Executive Committee, WPS Charge Card Corp.
23 Executive Committee, SMS Commission on Medical Care Plans
24 Executive Committee, SMS Council, and Executive Committee, Wisconsin Hospital Association
25 Conference on Health Care Costs
27 State Board of Pharmacy Examination
31 SMS Commission on Scientific Medicine

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

OB–GYN COLLEGE MEETING

The annual clinical meeting of the American College of Obstetricians and Gynecologists will be held at Bal Harbour, Fla., Apr. 28 to May 1. Details: ACOB, 79 W. Monroe, Chicago, Ill. 60603.

La Crosse Society

. . . at its November meeting featured two scientific speakers: Dr. Jay Levy of the UW Medical School addressed the group on the subject, "Neonatal Cardiac Problems," while Dr. George Griese* of the Marshfield Clinic discussed, "Noncardiac Neonatal Hypoxic Problems."

Dr. Ewald Pawsat*

. . . Fond du Lac, has been reappointed a member of the AMA's Council on Voluntary Health Agencies.

Dr. Gerald Faich

. . . Boston, Mass., recently was awarded a Mead–Johnson Residency Scholarship by the American College of Physicians. Doctor Faich graduated from the University of Wisconsin Medical School in 1968 and is currently interning at the Harvard Medical Unit of the Boston City Hospital.

Dr. James C. H. Russell*

. . . Fort Atkinson, has been reappointed a member of the AMA's Committee on Exercise and Physical Fitness.

Dr. Harold Wagner*

. . . chief pathologist at St. Catherine's Hospital in Kenosha, is the new Kenosha county coroner. He replaces Edward J. Wavro who did not seek reelection as coroner. This is believed to be the first time in Kenosha county history that a physician has served as coroner. Doctor Wagner has been a consultant to the Wisconsin State Crime Laboratory since 1963.

Dr. Jack L. Teasley*

. . . arrived in Saigon, Vietnam, Feb. 3, to serve two months of volunteer duty with a civilian hospital. He will be participating in a "Hand Surgery Rotation Service" which has been established by Dr. Alfred B. Swanson of Grand Rapids, Mich., in cooperation with the AMA's "Volunteer Physicians for Viet Nam" program. Doctor Teasley, a Milwaukee plastic surgeon, is the thirteenth Wisconsin physician to volunteer for Vietnam duty under this program.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF DECEMBER 16, 1968

NEW MEMBERS

Banda, Pedro N., 211 West Wisconsin Ave., Milwaukee 53203
Clemons, John E., 1836 South Ave., La Crosse 54601
Cline, Richard S., 401 N. Oneida St., Appleton 54911
Crow, Robert W., 4409 North 88th St., Milwaukee 53225
Forkner, William A., Kohler Co., Kohler 53044
Gani, Mukhtar A., 2320 North Lake Dr., Milwaukee 53211
Gonyo, James E., 8700 West Wisconsin Ave., Milwaukee 53226
Gore, Donald R., 1226 North 8th St., Sheboygan 53081
Larson, Arthur N., 624 North Eighth St., Manitowoc 54220
Manesis, John G., 401 N. Oneida St., Appleton 54911
Minich, William G., 3533 N. 27th St., Milwaukee 53216
Nickel, Frederick A., 1836 South Ave., La Crosse 54601
Overholt, Edwin L., 1836 South Ave., La Crosse 54601
Pesarillo, Servando, Arcadia Medical Center, Arcadia 54612
Sargent, James M., 1260 Valley Rd., Appleton 54911
Siy, Lucio C., 3975 North 68th St., Milwaukee 53216
Stripling, Burnell D., 516 Houston St., Marinette 54143
Taebel, D. W., 1836 South Ave., La Crosse 54601
Van Dreel, Richard A., 601 Reed Ave., Manitowoc 54220

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Busse, A. A., 130 South Main St., Jefferson 53549
Dominquez, Oscar, Marshfield, to 126 Eastly, San Antonio, Tex. 78217
Erickson, Norman Walter, 213 N. Center St., Beaver Dam 53916
Flynn, Richard T., Milwaukee, to P. O. Box 677, East Troy 53120
Graves, Joseph P., 6839—7th Ave., Kenosha 51340
Grauer, Curt G., 614 No. 3rd Ave., Wausau 54401
Harris, William C., Franksville, to 2405 Northwestern Ave., Racine 53404
Jackson, Reginald, Breese Point, Madison 53705
Keiser, Orris Sterling, De Pere, to 421 Main St., West De Pere 54178
Keller, Robert A., 1011 N. 8th St., Sheboygan 53081
Kreher, J. E., 522 W. 2nd St., Ashland 54806
Latorraca, Carol W., 7716 Geralayne Circle, Milwaukee 53213
Lawton, L. M., Wittenberg, to 2545 Western Ave., North Vancouver, Canada
Lloyd, Baldwin E., West Salem, to Hospitaly Loterany Monambaro, Fort Dauphin, Madagascar
Mann, Robert, 515—3rd Ave., East, Superior 54880
McGloin, Mary, 410 E. Wisconsin Ave., Neenah 54956
Oppert, H. E., 318 W. Decker St., Viroqua 54665
Peterman, Mynie Gust, 1962 N. Prospect Ave., Milwaukee 53202
Poll, Marvin, 2500 W. Lincoln Ave., Milwaukee 53215
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Sanford, Leonard L., La Farge, to Hillsboro 54634
Schroeder, Kenneth P., 3909 W. River Lane, Milwaukee 53209
Siedenburg, Richard, 106 E. John St., Jefferson 53549
Seidl, Joseph A., 1517 Beechwood Lane, Grafton 53024
Starr, Robert A., 318 W. Decker St., Viroqua 54665
Wrigley, John B., River Falls, to 302 S. Somerton Rd., Cleveland Heights, Ohio 44118

REMOVED FROM MEMBERSHIP

Beaumier, John H., Wood County, transferred to North Dakota
Dominguez, Oscar, Wood County, transferred to Texas
Geitz, Marten, Wood County, transferred to Texas
Gordon, Robert P., Jr., Wood County, transferred to Illinois
Koch, C. B., Juneau County, resigned
Mooney, Francis L., Sheboygan County, resigned
Richards, Robert N., Wood County, transferred to North Dakota
Silvia, Stephen E., Wood County, transferred to Minnesota
Sun, Kwoh Cheng, Barron–Washburn–Sawyer–Burnett County, transferred to Michigan

DEATHS

Shields, Gregory G., Wood County, Nov. 12, 1968
Gillette, F. J., nonmember, Nov. 13, 1968
Krembs, M. Alex, Milwaukee County, Nov. 19, 1968
Hougen, E. T., nonmember, Nov. 22, 1968
Notbohm, D. R., nonmember, Nov. 29, 1968
Thomas, Edgar, nonmember, Dec. 5, 1968
Stoddard, Frederick J., Milwaukee County, Dec. 7, 1968

BROCHURE: PAIN

A new brochure, PAIN, explores the nature of pain and man's attempts through the ages to endure it, cure it, explain it, and, at times, to use it for his own purposes.

Issued by the National Institute of General Medical Sciences, a component of the National Institutes of Health, the brochure explains why pain, a universal experience, defies universal definition.

The brochure PAIN makes a strong case for research in the nature of pain, for special training for physicians, and the development of new diagnostic and treatment techniques, including analgesics that control chronic pain over long periods without producing addiction.

Single copies of PAIN may be obtained without charge from the Information Office, National Institute of General Medical Sciences, National Institutes of Health, Bethesda, Md. 20014.

Quantity copies may be purchased at 15 cents a copy, $11.25 a 100, from Superintendent of Documents, Government Printing Office, Washington, D. C. 20402.

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"Medicine in Wisconsin — 1969"

128th ANNUAL MEETING

STATE MEDICAL SOCIETY OF WISCONSIN

MAY 13–15, 1969
MILWAUKEE

EDGAR S. GORDON, M.D.
General Chairman

The Commission on Scientific Medicine is pleased to invite you to attend the 1969 Annual Meeting of the State Medical Society of Wisconsin, in Milwaukee, May 13 through 15. The theme of the scientific program is: "Medicine in Wisconsin—1969." A wide variety of subjects is offered for your scientific exploration. The meeting this year is endeavoring to bring pertinent, updated information to the membership so that meaningful, take-home, practical benefits will inure for you in your practice.

All physicians are invited to attend the 1969 Annual Meeting which emphasizes a variety of specialty subjects. On the following pages you will find a complete schedule of the scientific program of your choice and we urge you to visit the technical and scientific exhibits. A printed program will be mailed to member physicians in mid-April. We hope to see you in Milwaukee May 13–15.

Sincerely,

Edgar S. Gordon MD

EDGAR S. GORDON, M.D.
Chairman, Commission on Scientific Medicine

Timetable

NOTE: S–S: Sheraton–Schroeder Hotel

SUNDAY, MAY 11

Noon

12:00 Council Luncheon: East Room (5th Fl. S–S)

p.m.

2:00 Council Meeting: English Room (5th Fl. S–S)
6:00 Fifty-Year Club Dinner: Councilors, Officers, Wives and Special Guests (New Members of Fifty-Year Club and wives): East Room (5th Fl. S–S)

MONDAY, MAY 12

a.m.

8:00 Installation of exhibits: Milwaukee Auditorium

Noon

12:00 Board of Directors Wisconsin Academy of General Practice Luncheon: English Room (5th Fl. S–S)

p.m.

5:30 Auxiliary Board Meeting and Dinner: English Room (S–S)
6:00 Buffet Supper for Delegates and Officers: East Room (5th Fl. S–S) and Registration for House of Delegates (5th Fl. Foyer S–S)
7:00 First Session, House of Delegates: Ballroom (5th Fl. S–S)

TUESDAY, MAY 13

a.m.

7:30 PACE Breakfast: East Room (S–S)
8:00 Registration and Opening of Exhibits: Milwaukee Auditorium
9:00 Auxiliary: Registration and Continental Breakfast: Loraine Room (S–S)
9:00 Reference Committees: Resolutions and Amendments: Ballroom (5th Fl. S–S); Reports of Officers: Parlor G (4th Fl. S–S); Reports of Standing Committees: Parlor H (4th Fl. S–S); and Finances: Parlor I (4th Fl. S–S)
9:30 Auxiliary Business Meeting: Loraine Room (S–S)
9:30—Scientific Program: "The Radiologist Looks at Internal Medicine": Milwaukee Auditorium

Noon

12:00 Clinic Managers Luncheon: Pfister Hotel

p.m.

12:30 Auxiliary Luncheon: Woman's Club
12:30 Scientific Luncheons: 4th and 5th Floors (S–S)
2:00 Scientific Programs: Milwaukee Auditorium
Internal Medicine
Pathology
Radiology
Utilization Review
2:15 Woman's Auxiliary Tour of Memorial Art Center and Mitchell Park Conservatory
3:00 Nominating Committee: Room 504 (5th Fl. S–S)
6:00 Marquette Alumni Dinner: Milwaukee Athletic Club
6:00 Radiology Dinner (Members only): Milwaukee Yacht Club
6:30 Registration for House of Delegates (5th Fl. Foyer S–S)
7:30 Second Session, House of Delegates: Ballroom (5th Fl. S–S)

WEDNESDAY, MAY 14

a.m.

7:30 Catholic Physicians Guild Breakfast: East Room (S–S)
8:00 Registration for Third session of House of Delegates (5th Fl. S–S)
8:30 Registration and Exhibits: Milwaukee Auditorium
9:00 Auxiliary: Registration and Continental Breakfast: Loraine Room (S–S)
9:00 Third Session, House of Delegates: Ballroom (5th Fl. S–S)
9:30 Auxiliary Business Meeting: Loraine Room (S–S)
9:30 Scientific Program: Milwaukee Auditorium
Obstetrics and Gynecology
9:45 Special Program—Senator Gaylord A. Nelson: Ballroom (5th Fl. S–S)
10:30 Council Meeting: English Room (5th Fl. S–S)

p.m.

12:30 Council Luncheon: English Room (5th Fl. S–S)
12:30 Scientific Luncheons (4th and 5th Fls. S–S)
12:30 Auxiliary Luncheon: Empire Room (S–S)
2:00 Scientific Programs: Milwaukee Auditorium
Allergy
Dermatology
Neurology
Obstetrics & Gynecology
6:30 President's Reception (For those attending Dinner): East Room (5th Fl. S–S)
7:15 Annual Dinner: Ballroom (5th Fl. S–S)

THURSDAY, MAY 15

a.m.

8:00 "Wet Clinic": Wisconsin Surgical Society: Milwaukee County General Hospital
8:30 Registration and Exhibits: Milwaukee Auditorium
9:00 Ophthalmology Demonstrations and Movies: East Room and Room 504 (5th Fl. S–S)
9:30 Scientific Programs: Milwaukee Auditorium and S–S
9:30 Otolaryngology Scientific Program: Milwaukee Auditorium
10:00 Resident-Intern Program: Milwaukee Auditorium

Noon

12:00 Past Presidents Luncheon: Parlor G (4th Fl. S–S)

p.m.

12:30 Scientific Luncheons (4th and 5th Fls. S–S)
2:00 Scientific Programs: Milwaukee Auditorium
Anesthesiology
Surgery
Orthopedics
Otolaryngology
2:00 Ophthalmology Scientific Program: East Room (5th Fl. S–S)
3:45 Closing of exhibits: Milwaukee Auditorium
6:30 Wisconsin Orthopaedic Society Dinner (Members only): Milwaukee Athletic Club
6:30 Ophthalmology Dinner: University Club
7:00 Wisconsin Surgical Society Dinner (Members only): Milwaukee Athletic Club

IMPORTANT INFORMATION

★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Street. The time Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday, 8:30–4:00 p.m.; and Thursday, 8:30 a.m.–3:30 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Senior and junior medical students will be admitted on Wednesday and Thursday, May 15–16. Medical assistants and hospital personnel will be admitted on Thursday, May 16 *only after 11:00 a.m.* Interns and residents will be admitted without registration fee, any time during meeting, *if certified by hospital.* Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies will be admitted by membership cards.

★ **VA and M.D.'s IN MILITARY SERVICE:** *Members of the Veterans Administration must be members of the State Medical Society to be admitted.* Physicians in the armed services admitted by presenting certification of current military status.

★ **TELEPHONE SERVICE:** Registration Desk, Milwaukee Auditorium—271–9609. For Milwaukee MDs, Direct call through 273–7700, Ext. 200, and it will be relayed to a special phone near the main meeting hall at the Auditorium. For those at Luncheons: 5th Floor Foyer phone at Sheraton–Schroeder Hotel—271–7250. Tell your secretary the *room number of the luncheon, so we can locate you!* (Your ticket has this information)

★ **RESERVATIONS FOR NOON LUNCHEONS:** For Round Tables, at registration desk between 8:00 a.m. and 11:00 a.m., starting Tuesday, May 13. If any tickets remain unsold by 11:30 a.m. the day of the luncheon, they can be purchased in fifth floor foyer, Sheraton–Schroeder Hotel.

★ **RESERVATIONS FOR ANNUAL DINNER:** May be obtained at the registration desk in the Auditorium from 8:00 a.m. to 4:00 p.m. Tuesday and Wednesday. Attendance at the dinner Wednesday night by ticket only. Limit 500.

NOTIFY YOUR SECRETARY AND HOME

A special phone will be installed at the Registration Desk, Milwaukee Auditorium, through which you can be reached if you are attending the scientific programs.

THIS NUMBER IS: (Area Code 414)—271–9609

Times when you may be reached thru this phone:

Tuesday, May 13 and Wednesday, May 14: 8:30 a.m.-4:30 p.m.

Thursday, May 15: 8:30 a.m.–4:00 p.m.

TELL YOUR HOME AND SECRETARY WHERE YOU WILL BE SLEEPING, SO YOU CAN BE REACHED THERE AT OTHER TIMES WHEN YOU ARE IN MILWAUKEE.

EDGAR S. GORDON, MD
Chairman, Commission on Scientific Medicine

JACK A. KILLINS, MD
Program Chairman

ANNUAL MEETING PROGRAM

ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

EDGAR S. GORDON, M.D. ..... Madison
Chairman

JACK A. KILLINS, M.D. ..... Green Bay
General Program Chairman

EINAR R. DANIELS, M.D. ..... Milwaukee
Scientific Exhibits

NORMAN O. BECKER, M.D. ..... Fond du Lac
SIGURD E. SIVERTSON, M.D. ..... Madison
ALBERT G. MARTIN, M.D. ..... Milwaukee
ROBERT A. STARR, M.D. ..... Viroqua
ANTHONY V. PISCIOTTA, M.D. ..... Milwaukee
GERALD J. DERUS, M.D. ..... Madison
BEN R. LAWTON, M.D. ..... Marshfield

Ex officio:

GERALD A. KERRIGAN, M.D. ..... Milwaukee
Dean, Marquette School of Medicine

PETER L. EICHMAN, M.D. ..... Madison
Dean, University of Wisconsin Medical School

V. S. FALK, JR., M.D. ..... Edgerton
Medical Editor, *The Wisconsin Medical Journal*

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

House of Delegates

The House of Delegates meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the initial session. Reference committees will meet Tuesday morning, with reports to be made at the Tuesday evening session. The Nominating Committee will meet Tuesday afternoon and the third session, with election of officers, will be held on Wednesday morning.

Society members are urged to participate in the discussions on reports, resolutions, and nominations in the open hearings of the reference committees.

SCHEDULE

MONDAY, MAY 12

p.m.
6:00 BUFFET SUPPER for Delegates and Officers: East Room, 5th Fl. (S–S) and REGISTRATION for first session of House of Delegates, 5th Floor Foyer, Hotel Sheraton–Schroeder

7:00 FIRST SESSION, House of Delegates, Ballroom, 5th Floor, Hotel Sheraton–Schroeder

TUESDAY, MAY 13

a.m.
9:00 REFERENCE COMMITTEES: Hotel Sheraton–Schroeder
- Resolutions and Amendments: Ballroom (5th Fl.)
- Reports of Officers: Parlor G (4th Fl.)
- Reports of Standing Committees: Parlor H (4th Fl.)
- Finances: Parlor I (4th Fl.)

p.m.
3:00 NOMINATING COMMITTEE: Room 504, 5th Floor, Hotel Sheraton–Schroeder

6:30 REGISTRATION for second session: 5th Fl. Foyer, Hotel Sheraton–Schroeder

7:30 SECOND SESSION, House of Delegates, Ballroom (5th Fl.), Hotel Sheraton–Schroeder

WEDNESDAY, MAY 14

a.m.
8:00 REGISTRATION for third session: 5th Fl. Foyer, Hotel Sheraton–Schroeder

9:00 THIRD SESSION: Ballroom (5th Fl.), Hotel Sheraton–Schroeder

ANNUAL PHOTOGRAPHY EXHIBIT
Bruce Hall, Milwaukee Auditorium

Beautiful and exciting pictures taken by physicians. Awards will be made before the Annual Meeting.

OUT-OF-STATE GUEST SPEAKERS

ALPERT, JOEL J., MD
Child Development Center, Boston, Mass.

BEAHRS, OLIVER H., MD
Professor of Surgery, Mayo Graduate School of Medicine, University of Minnesota, Rochester, Minnesota

CALLAHAN, ALSTON, MD, F.A.C.S.
President, The Eye Foundation, Incorporated, Birmingham, Alabama

FARR, RICHARD S., MD
Chairman, Department of Clinical Biology and Head, Division of Allergy and Immunology, Scripps Clinic and Research Foundation, La Jolla, California

KRANTZ, KERMIT E., MD
Professor and Chairman of Department of Gynecology and Obstetrics, Professor of Anatomy, University of Kansas Medical Center, Kansas City, Kansas

SISSON, GEORGE A., MD
Professor and Chairman, Department of Otolaryngology & Maxillofacial Surgery, The Medical School, Northwestern University, Chicago, Illinois

SMITH, WILLIAM S., MD
Professor and Head, Section of Orthopedic Surgery, University of Michigan Medical School, Ann Arbor, Michigan

WAGNER, HENRY N., JR., MD
Professor of Radiology and Radiological Science, The Johns Hopkins Medical Institutions, Baltimore, Maryland

WITEBSKY, ERNEST, MD
Distinguished Professor of Bacteriology and Immunology, Director, The Center for Immunology, State University of New York at Buffalo, Buffalo, New York

WEDNESDAY, MAY 14
9:45 a.m.

Immediately following the adjournment *sine die* of the House of Delegates there will be a special program to which all physician members are invited.

The Honorable Gaylord A. Nelson
United States Senator, Wisconsin

will present an address entitled
"The Senate Drug Hearings"
in the Ballroom, fifth floor, of
Hotel Sheraton–Schroeder

1969 ANNUAL MEETING PROGRAM

STATE MEDICAL SOCIETY OF WISCONSIN • MAY 13–15 • MILWAUKEE

TUESDAY, MAY 13

8:00—REGISTRATION AND VIEWING OF EXHIBITS

MILWAUKEE AUDITORIUM

MORNING SCIENTIFIC PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

INTERNAL MEDICINE

Chairman: OVID O. MEYER, MD, Madison

THE RADIOLOGIST LOOKS AT INTERNAL MEDICINE

This will be an all-day program. The Section on Internal Medicine will have an internist and a radiologist carrying on a "give and take session" on the following categories (two in morning and two in afternoon):

9:30—CARDIOVASCULAR SYSTEM

Richard H. Wasserburger, MD, Madison
Professor of Medicine, University of Wisconsin Medical School
Richard Logan, MD, Madison
Thomas L. Carter, MD, Madison

10:30—RECESS TO VIEW EXHIBITS

11:00—THE CHEST

Helen A. Dickie, MD, Madison
Professor of Medicine, University of Wisconsin Medical School

John H. Juhl, MD, Madison
Professor of Radiology, University of Wisconsin Medical School

12:30—SCIENTIFIC LUNCHEONS

HOTEL SHERATON–SCHROEDER

1. INTERNAL MEDICINE

RECENT ADVANCES IN DRUG THERAPY

Ovid O. Meyer, MD, Madison
Professor of Medicine, University of Wisconsin Medical School

ENGLISH ROOM: FIFTH FLOOR

2. INTERNAL MEDICINE

SOME CURRENT MISCONCEPTIONS—GASTROINTESTINAL DISEASE

James W. Manier, MD, Marshfield

PARLOR B: FOURTH FLOOR

3. INTERNAL MEDICINE

MANAGEMENT OF THE PATIENT WITH CHRONIC RENAL FAILURE

Richard E. Rieselbach, MD, Madison
Assistant Professor of Medicine, University of Wisconsin Medical School

PARLOR C: FOURTH FLOOR

4. INTERNAL MEDICINE

COMPUTER-BASED MEDICAL INTERVIEWING

Warner V. Slack, MD, Madison
Assistant Professor of Medicine and Computer Sciences, University of Wisconsin Medical School

PARLOR E: FOURTH FLOOR

5. PATHOLOGY

IMMUNOLOGY TODAY AND ITS POTENTIAL FOR TOMORROW

Ernest Witebsky, MD, Buffalo, N. Y.

Chairman: ALFRED MEYERS, MD, Milwaukee

PERE–MARQUETTE ROOM: FIFTH FLOOR

6. RADIOLOGY

CURRENT STUDIES OF PULMONARY EMBOLISM

Henry N. Wagner, Jr., MD, Baltimore, Md.

Chairman: LAWRENCE L. LARSEN, MD, Milwaukee

PARLOR A: FOURTH FLOOR

7. PUBLIC HEALTH

COMPREHENSIVE HEALTH PLANNING AS IT RELATES TO WISCONSIN

George H. Handy, MD, Madison
Director, Bureau of Comprehensive Health Planning, State of Wisconsin

PARLOR D: FOURTH FLOOR

8. SURGERY

ORGAN TRANSPLANTATION—PRESENT AND FUTURE

Derward Lepley, Jr., MD, Milwaukee
Professor of Thoracic-Cardiovascular Surgery, Marquette School of Medicine

EAST ROOM: FIFTH FLOOR

TUESDAY *continued*

WITEBSKY

WAGNER

KRANTZ

AFTERNOON SCIENTIFIC PROGRAMS

MILWAUKEE AUDITORIUM

FOUR PROGRAMS RUNNING CONCURRENTLY: Internal Medicine, Pathology, Radiology, and Utilization Committees

1. INTERNAL MEDICINE

JUNEAU HALL, MILWAUKEE AUDITORIUM

Chairman: WILLIAM S. MIDDLETON, MD, Madison

This is a continuation of the morning program.

2:00—HOW THE INTERNIST AND THE RADIOLOGIST LOOK AT THE G. I. TRACT

James W. Manier, MD, Marshfield
Section of Gastroenterology, Marshfield Clinic

Dayton H. Hinke, MD, Marshfield
Section of Diagnostic Radiology, Marshfield Clinic, and Assistant Clinical Professor of Radiology, University of Wisconsin Medical School

3:00—RECESS TO VIEW EXHIBITS

3:30—G. U. TRACT

Robert O. Burns, MD, Madison
Associate Professor of Medicine, University of Wisconsin Medical School

Charles Benkendorf, MD, Green Bay

2. PATHOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Chairman: ALFRED MEYERS, MD, Milwaukee
Clinical Instructor in Pathology, Marquette School of Medicine

2:00—CURRENT CONCEPTS IN PRE-SURGICAL COAGULATION SCREENING AND EVALUATION

David J. LaFond, MD, Milwaukee
Assistant Clinical Professor of Pathology, Marquette School of Medicine (Associate Pathologist, Lutheran Hospital of Milwaukee)

2:30—THE IMPACT OF IMMUNOLOGY ON THE PRACTICE OF MEDICINE

Ernest Witebsky, MD, Buffalo, N. Y.
Distinguished Professor of Bacteriology and Immunology, School of Medicine, State University of New York at Buffalo

3:00—RECESS TO VIEW EXHIBITS

3:30—LABORATORY AIDS FOR CLINICIANS IN EVALUATING ACID BASE METABOLISM

Yoshiro Taira, MD, Milwaukee
Assistant Clinical Professor of Pathology, Marquette School of Medicine

3:50—THE NEEDLE VS. THE CHEMICAL LIVER BIOPSY

Paul R. Glunz, MD, Beaver Dam
Pathologist, Watertown Memorial Hospital and St. Joseph's Hospital, Hartford; Pathology Clinic, Beaver Dam

4:15—CLINICAL IMPORTANCE OF BLOOD BANKING

Ruth Dalton, MD, La Crosse
Associate Pathologist, St. Francis Hospital, La Crosse

3. RADIOLOGY

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Chairman: LAWRENCE L. LARSEN, MD, Milwaukee
Clinical Instructor in Radiology, Marquette School of Medicine

2:00—EXPERIENCE WITH PARATHYROID SCANNING AT MILWAUKEE COUNTY GENERAL HOSPITAL

Richard A. Holmes, MD, Milwaukee
Assistant Professor of Medicine; Assistant Professor of Medicine in Radiology, Marquette School of Medicine

2:25—TEN YEARS EXPERIENCE WITH I–131 THERAPY FOR HYPERTHYROIDISM AT ST. JOSEPH'S HOSPITAL, MILWAUKEE

Richard A. Kessler, MD, Milwaukee

2:50—TANTALUM BRONCHOGRAPHY—A NEW EXPERIMENTAL APPROACH: MILWAUKEE COUNTY GENERAL HOSPITAL

James E. Youker, MD, Milwaukee
Professor and Chairman, Division of Radiology, Marquette School of Medicine

3:00—RECESS TO VIEW EXHIBITS

Woman's Auxiliary PROGRAM

MONDAY, MAY 12

P.M.

5:30 Pre-Convention Board Meeting and Dinner: English Room, Hotel Sheraton–Schroeder

TUESDAY, MAY 13

A.M.

9:00 Registration and Continental Breakfast: Loraine Room, Hotel Sheraton–Schroeder

9:30 First Business Session: Loraine Room, Hotel Sheraton–Schroeder

P.M.

12:30 Luncheon: Woman's Club

2:15 Concert by Angel-aires of Holy Angels Academy, Milwaukee, and tour of Memorial Art Center and Mitchell Park Conservatory

WEDNESDAY, MAY 14

A.M.

9:00 Registration and Continental Breakfast: Loraine Room, Hotel Sheraton–Schroeder

9:30 Second Business Session: Loraine Room, Hotel Sheraton–Schroeder

P.M.

12:30 Luncheon: Empire Room, Hotel Sheraton–Schroeder

Fashion Show by Betty Johnson of Thiensville
Installation of Officers, Mrs. Howard G. Ellis, Des Moines, Iowa; Regional Vice-President, Woman's Auxiliary to the AMA

6:30 President's Reception (all those attending Annual Dinner, State Medical Society): East Room, Hotel Sheraton–Schroeder

7:15 Annual Dinner of the State Medical Society: Crystal Ballroom, Hotel Sheraton–Schroeder

MUSEUM OF MEDICAL PROGRESS AND STOVALL HALL OF HEALTH

Prairie du Chien, Wis.

Open April 15

TUESDAY *continued*

3:30—THE VALUE OF BRAIN SCANNING IN THE STUDY OF CONVULSIVE DISORDERS

P. David Lemper, MD, Milwaukee

Richard A. Holmes, MD, Milwaukee

4:00—NEW RADIOPHARMACEUTICALS AND CLINICAL NUCLEAR MEDICINE

Henry N. Wagner, Jr., MD, Baltimore

Professor of Radiology and Radiological Science, The Johns Hopkins Medical Institutions, Baltimore, Md.

4:30—BUSINESS MEETING

Wisconsin Radiological Society

4. UTILIZATION REVIEW

WALKER HALL, MILWAUKEE AUDITORIUM

Chairman: JULIUS M. MEYER, MD, Milwaukee

Associate Clinical Professor of Medicine, Marquette School of Medicine

2:00—THE USE OF AUTOMATED TECHNIQUES IN AIDING UTILIZATION COMMITTEES

Sidney Shindell, MD, Milwaukee

Professor and Chairman, Division of Preventive Medicine, Marquette School of Medicine

3:00—RECESS TO VIEW EXHIBITS

EVENING PROGRAMS

6:00—DINNER: Marquette Medical Alumni Association

(Open to all Marquette medical alumni, their wives, and guests)

Milwaukee Athletic Club

Chairman: ROBERT H. HERZOG, Milwaukee
Executive Secretary, Marquette Alumni Association

Presentation of Alumnus of the Year Award.

6:00—DINNER: Wisconsin Radiological Society

(Members only)

Milwaukee Yacht Club

Chairman: ROBERT C. FEULNER, MD, Waukesha

Speaker to be announced

CLINIC MANAGERS LUNCHEON

Tuesday, May 13—12:00 Noon

Hotel Pfister

WEDNESDAY, MAY 14

MORNING SCIENTIFIC PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

OBSTETRICS & GYNECOLOGY

Chairman: THOMAS J. RICE, MD, Marshfield
President, Wisconsin Society of Obstetrics and Gynecology

Moderator: FREDERICK J. HOFMEISTER, MD, Milwaukee
Associate Clinical Professor of Gynecology and Obstetrics, Marquette School of Medicine; Chairman, Department of Gynecology and Obstetrics, Lutheran Hospital of Milwaukee

Six hours of credit by Wisconsin Academy of General Practice

9:30—HISTORY OF MATERNAL MORTALITY STUDY GROUP

T. A. Leonard, MD, Madison
Chairman, Maternal Mortality Study Committee, Division of Maternal and Child Welfare of the Commission on State Departments of the State Medical Society of Wisconsin

9:45—TRENDS IN MATERNAL MORTALITY IN WISCONSIN

F. J. Hofmeister, MD, Milwaukee

10:00—DIAGNOSIS AND TREATMENT OF SEPTIC SHOCK

K. E. Krantz, MD, Kansas City, Kan.
Professor and Chairman of Department of Obstetrics and Gynecology and Professor of Anatomy, University of Kansas Medical Center

10:15—ANTIBIOTICS IN OBSTETRICS

Allan C. Kind, MD, Madison
Assistant Professor of Medicine, University of Wisconsin Medical School

10:30—RECESS TO VIEW EXHIBITS

11:00—OBSTETRIC HEMORRHAGE

Eleanor Delfs, MD, Milwaukee
Professor of Gynecology and Obstetrics, Marquette School of Medicine

11:15—PANEL: YOUR MATERNAL MORTALITY COMMITTEE IN ACTION

Moderator: F. J. HOFMEISTER, MD, Milwaukee

Participants:
Kermit E. Krantz, MD, Kansas City
Thomas A. Leonard, MD, Madison
Allan C. Kind, MD, Madison
Eleanor C. Delfs, MD, Milwaukee

ANNUAL DINNER

WEDNESDAY EVENING—MAY 14

As President of the State Medical Society, I am anxious to make this 128th Annual Meeting Dinner an outstanding success and that it be a fun evening for you and your wife. We will have superb entertainment with the Varsity Glee Club from the University of Wisconsin and we will be happy to honor our visiting guests and friends from other ancillary organizations. There will be no long speeches, so plan to attend and have fun.

Sincerely,

W. D. James M.D.

William D. James, M.D.
President

PRESIDENT'S RECEPTION—6:30 P. M.
East Room: Hotel Sheraton–Schroeder

ANNUAL DINNER—7:15 P. M.
Ballroom: Hotel Sheraton–Schroeder

SPECIAL ENTERTAINMENT:

STEVE SWEDISH and his orchestra will entertain during the dinner. Our featured entertainment will be the VARSITY GLEE CLUB from the University of Wisconsin under the direction of John M. Clark who is associated with the University of Wisconsin School of Music in Madison.

$10.00 Per Person

MAKE RESERVATIONS BY MAIL OR AT REGISTRATION DESK BEFORE NOON, WEDNESDAY

12:30-SCIENTIFIC LUNCHEONS

HOTEL SHERATON–SCHROEDER

1. INTERNAL MEDICINE

SOME PROMISING THERAPEUTIC ADVANCES IN NEUROPSYCHIATRIC DISORDERS

William S. Middleton, MD, Madison
Professor of Medicine Emeritus; Dean of Medicine Emeritus; University of Wisconsin Medical School

PARLOR A: FOURTH FLOOR

2. OBSTETRICS AND GYNECOLOGY

SYMPOSIUM ON SEXUAL ATTITUDES AND MARRIAGE COUNSELING

Moderator: THOMAS J. RICE, MD, Marshfield

A MATRIARCHAL SOCIETY—ITS PROBLEMS

Kermit E. Krantz, MD, Kansas City, Kan.

EAST ROOM: FIFTH FLOOR

3. NEUROLOGY

THE MODERN MEDICAL CENTER AS AN ADJUNCT TO NEUROLOGICAL PRACTICE

Peter L. Eichman, MD, Madison
Dean and Professor of Neurology, University of Wisconsin Medical School

PARLOR C: FOURTH FLOOR

4. DERMATOLOGY

CONTACT DERMATITIS: PRACTICAL OFFICE MANAGEMENT

William F. Schorr, MD, Marshfield
Department of Dermatology, Marshfield Clinic

PARLOR B: FOURTH FLOOR

5. ALLERGY

THE CHANGING CONCEPT OF ALLERGY

Richard S. Farr, MD, La Jolla, Calif.

Chairman: DAVID M. GLASSNER, MD, Milwaukee

PARLOR D: FOURTH FLOOR

6. SURGERY

THE PRESENT STATE OF DIRECT AND INDIRECT MYOCARDIAL REVASCULARIZATION

W. Dudley Johnson, MD, Milwaukee
Assistant Professor of Surgery, Marquette School of Medicine

PERE–MARQUETTE ROOM: FIFTH FLOOR

FARR

SISSON

SMITH

7. OFFICE MANAGEMENT

IMPROVED EFFICIENCY IN OFFICE PRACTICES

Oscar W. Gaarder, Madison
Paul R. Miller, Madison
From Gaarder–Miller, Inc., Madison (Professional Management Consultants). Both are members of the National Society of Professional Business Consultants

PARLOR F: FOURTH FLOOR

8. PEDIATRICS

POISON CONTROL—WHY THE FUSS?

Joel J. Alpert, MD, Boston
Child Development Center

Chairman: JOHN D. STUHLER, MD, Wauwatosa

PARLOR E: FOURTH FLOOR

AFTERNOON SCIENTIFIC PROGRAMS

MILWAUKEE AUDITORIUM

FOUR PROGRAMS RUNNING CONCURRENTLY: Obstetrics & Gynecology, Allergy, Dermatology, and Neurology

1. OBSTETRICS AND GYNECOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

Chairman: THOMAS J. RICE, MD, Marshfield

Continuation of Symposium on Sexual Attitudes and Marriage Counseling

2:00—THE TIRED MOTHER'S SYNDROME

Carl A. Whitaker, MD, Madison
Professor of Psychiatry, University of Wisconsin Medical School

2:30—APPLYING OUR KNOWLEDGE OF HUMAN SEXUAL RESPONSE

K. E. Krantz, MD, Kansas City, Kan.

3:00—RECESS TO VIEW EXHIBITS

WEDNESDAY *continued*

3:30—MIND READING AND MARITAL DISORDERS

Gerald D. Erickson, ACSW, Marshfield
Coordinator of Mental Health Planning, Marshfield Clinic Foundation

3:45—PANEL

Moderator: THOMAS J. RICE, MD, Marshfield

Participants:
Kermit E. Krantz, MD, Kansas City
Carl A. Whitaker, MD, Madison
Gerald Erickson, ACSW, Marshfield

4:30—BUSINESS MEETING

Wisconsin Society of Obstetrics and Gynecology

Chairman: THOMAS J. RICE, MD, Marshfield
President, Wisconsin Society of OB-GYN

2. *ALLERGY*

WALKER HALL, MILWAUKEE AUDITORIUM

Chairman: DAVID M. GLASSNER, MD, Milwaukee
Assistant Clinical Professor of Medicine, Marquette School of Medicine

2:00—SOME SERIOUS BIOLOGICAL CONSEQUENCES FOLLOWING INGESTION OF ASPIRIN

Richard S. Farr, MD, La Jolla, Calif.
Chairman, Department of Clinical Biology; Head of Division of Allergy and Immunology, Scripps Clinic and Research Foundation

3:00—RECESS TO VIEW EXHIBITS

A Special Annual Meeting Feature

MEDICAL ART SALON

Oils - Water Colors - Sculpture

MILWAUKEE AUDITORIUM

MAY 13–14–15

Sponsored by the Woman's Auxiliary to the State Medical Society of Wisconsin

3:30—PANEL DISCUSSION

Led by members of Wisconsin Allergy Society on following subjects:

- **ASTHMA**

  Charles E. Reed, MD, Madison
  Professor of Medicine, University of Wisconsin Medical School

- **ALLERGIC EMERGENCIES**

  James C. Curry, MD, Appleton

- **URTICARIA**

  Robert M. Heywood, MD, Marshfield
  Assistant Clinical Professor of Medicine, University of Wisconsin Medical School; Marshfield Clinic

- **DRUG REACTIONS**

  Harry R. Weil, MD, Milwaukee
  Assistant Clinical Professor of Medicine, Marquette School of Medicine

3. *DERMATOLOGY*

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Chairman: HARRY R. FOERSTER, JR., MD, Milwaukee

A program of selected dermatological conditions, including those of the hair and nails. All presentations will be brief, and will illustrate some of the common problems of diagnosis and treatment. The program will conclude with a question and answer period.

2:00—

- **TINEA VERSICOLOR**

  John R. Marnocha, MD, Green Bay

- **PYOGENIC GRANULOMA**

  Donald S. Schuster, MD, Madison
  Assistant Clinical Professor of Dermatology, University of Wisconsin Medical School

- **PHOTOSENSITIVITY DUE TO DRUGS**

  John W. Faber, MD, Neenah

- **LICHEN PLANUS**

  James F. Hildebrand, MD, Sheboygan

- **FACTITIAL DERMATITIS**

  Roger Laubenheimer, MD, Milwaukee

- **PITYRIASIS ROSEA**

  Marvin Kagen, MD, Appleton

WEDNESDAY *continued*

- **SHOE DERMATITIS**

  William F. Schorr, MD, Marshfield
  Clinical Instructor in Medicine, University of Wisconsin Medical School, Madison

- **PECULIAR VESICULAR ERUPTIONS**

  Robert R. Baumann, MD, Monroe
  Assistant Clinical Professor of Medicine, University of Wisconsin Medical School, Madison

3:00—RECESS TO VIEW EXHIBITS

3:30—● AXILIARY DERMATITIS

Everett P. Kirch, MD, Kenosha

- **HAIR LOSS IN WOMEN**

  Kenneth J. Dempsey, MD, Menomonee Falls
  Clinical Instructor in Dermatology, Marquette School of Medicine, Milwaukee

- **KERION INFECTIONS**

  William C. Miller, MD, Wausau

- **NAIL DISORDERS**

  Edward P. Lauerman, MD, Racine

FOLLOWING discussion of the 12 previously mentioned topics, there will be a QUESTION AND ANSWER PERIOD.

4. NEUROLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Chairman: FRANCIS M. FORSTER, MD, Madison

Professor of Neurology, University of Wisconsin Medical School

2:00—THE STROKE PROGRAM OF THE WISCONSIN REGIONAL MEDICAL PROGRAM

Philip T. White, MD, Milwaukee
Professor and Chairman, Department of Neurology, Marquette School of Medicine

John B. Baker, MD, Milwaukee
Assistant Professor of Neurology, Marquette School of Medicine

2:15—MEDICAL TREATMENT OF PARKINSONISM

Keith C. Bogart, MD, Madison
Assistant Professor of Neurology, University of Wisconsin Medical School

2:30—CONDITIONING TREATMENT OF MOVEMENT DISORDERS

Harold E. Booker, MD, Madison
Associate Professor of Neurology, University of Wisconsin Medical School

Charles S. Cleeland, PhD, Madison
Assistant Professor of Neurology, University of Wisconsin Medical School

2:45—MEDICOLEGAL PROBLEMS OF THE NEUROLOGIC PATIENT

Francis Kruse, Jr., MD, Marshfield
Marshfield Clinic; Assistant Clinical Professor of Neurology, University of Wisconsin Medical School

3:00—RECESS TO VIEW EXHIBITS

3:30—PRESENT STATUS OF THE DIAGNOSIS AND TREATMENT OF MULTIPLE SCLEROSIS

Cornelius L. Hopper, MD, Madison
Assistant Professor of Neurology, University of Wisconsin Medical School

4:15—ROLE OF NEUROPSYCHOLOGICAL EVALUATION IN MULTIPLE SCLEROSIS

Hallgrim Klove, PhD, Madison
Associate Professor of Neurology, University of Wisconsin Medical School

Charles G. Matthews, PhD, Madison
Associate Professor of Neurology, University of Wisconsin Medical School

4:30—GENETIC COUNSELING IN DISEASES OF THE NERVOUS SYSTEM

Richard F. Daly, MD, Madison
Assistant Professor of Neurology, University of Wisconsin Medical School

4:45—ELECTROENCEPHALOGRAPHY IN MEDICAL AND NEUROLOGIC PROBLEMS

Jack D. Grabow, MD, Madison
Assistant Professor of Neurology, University of Wisconsin Medical School

EVENING PROGRAMS

6:30—PRESIDENT'S RECEPTION: State Medical Society

East Room: HOTEL SHERATON–SCHROEDER

7:15—ANNUAL DINNER: State Medical Society

Ballroom: HOTEL SHERATON–SCHROEDER

MAKE YOUR ROOM RESERVATIONS

On page 21, following this program, you will note a form to use for a room reservation at the Hotel Sheraton–Schroeder, Milwaukee. *Do not delay in making your reservation.*

THURSDAY, MAY 15

MORNING SCIENTIFIC PROGRAMS

FOUR PROGRAMS, SOME RUNNING CONCURRENTLY AND OTHERS CONTINUING THROUGHOUT THE DAY AND EVENING: Resident-Intern Papers, Ophthalmology, Otolaryngology, and Surgery

1. RESIDENT-INTERN PAPERS

This is a competitive program with cash awards of $100 each for the two winning presentations. One award known as the W. S. MIDDLETON AWARD and the second as the HARRY BECKMAN AWARD

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Chairman: EDGAR S. GORDON, MD, Madison

Chairman, Commission on Scientific Medicine of the State Medical Society of Wisconsin

10:00—● RESPIRATORY OBSTRUCTION IN THE INJURED ATHLETES—A NEW LOOK

Maurey Allen, MD, Madison
Department of Anesthesia, UW Medical Center

● INTERN QUESTIONNAIRE

John H. Greist, MD, Madison
Computer Science, UW Medical Center

● PANCREATIC RADIOGRAPHY—ANOTHER ATTEMPT

H. W. Harding, MD, Milwaukee
Department of Surgery, Marquette School of Medicine

● METABOLIC STUDIES IN WERNER'S SYNDROME

Jamie L. Jacobs, MD, Madison
Veterans Administration Hospital

● THE IMPLICATIONS OF SUCCESSFUL RATIONAL EMOTIVE PSYCHOTHERAPY FOR PSYCHOSOMATIC DISEASE MANAGEMENT

Maxie C. Maultsby, Jr., MD, Madison
Department of Medicine, University Hospitals

● EFFECT OF PHOSPHATE INFUSION ON GASTRIC SECRETION

Gordon D. Murley, MD, Milwaukee
Department of Surgery, Marquette School of Medicine

● CYCLE INJURIES: A COMPARATIVE STUDY
(as published in the *Wisconsin Medical Journal,* September 1968)

E. A. Pellegrino, Jr., MD, Madison
Department of Surgery, University Hospitals

● CEREBRAL INHIBITION OF GASTRIC SECRETION

D. H. Reigel, MD, Milwaukee
Veterans Administration Hospital, Wood

● RENAL SEGMENTAL STAINING TECHNIQUE EVALUATING INTRA-ARTERIAL INJECTION OF SUPRAVITAL STAINS

Charles W. Troup, MD, Milwaukee
Department of Urology, Veterans Administration Hospital, Wood

2. OPHTHALMOLOGY

HOTEL SHERATON–SCHROEDER

Chairman: M. D. DAVIS, MD, Madison

9:00 to 12:00—STEREOPHOTOGRAPHIC DEMONSTRATIONS

EAST ROOM (FIFTH FLOOR), HOTEL SHERATON–SCHROEDER

9:00 to 10:30 and
10:30 to 12:00—TWO SHOWINGS OF A ONE AND ONE-HALF HOUR MOVIE PROGRAM

Film Selector: GORDON L. BACKER, MD, Wausau

ROOM 504 (FIFTH FLOOR), HOTEL SHERATON–SCHROEDER

9:00 to 12:00—VISIT EXHIBITS AND EVENTS AT AUDITORIUM

YOUR ATTENTION is directed to Scientific Exhibit Nos. 28 and 29. You are urged to visit these and the Technical Exhibits.

3. OTOLARYNGOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

Chairman: JOHN K. SCOTT, MD, Madison

9:30—THE NODE IN THE NECK—DIAGNOSIS AND TREATMENT

George A. Sisson, MD, Chicago, Ill.
Chairman, Department of Otolaryngology, Northwestern University Medical School

10:00—PROBLEM CASE PRESENTATIONS IN EAR, NOSE, AND THROAT

- *Jerry E. Friedman, MD,* Milwaukee
- *John M. Mills, MD,* Green Bay
- *John R. Larsen, MD,* Manitowoc
- *Richard J. Fogle, MD,* Racine

10:30—RECESS TO VIEW EXHIBITS

THURSDAY *continued*

11:00—PANEL: MALIGNANT TUMORS OF THE HEAD AND NECK—DIAGNOSIS AND TREATMENT WITH CASE PRESENTATIONS

Moderator: ROGER H. LEHMAN, MD, Wood
Chief of Otolaryngology, Veterans Administration Center

Participants:

George A. Sisson, MD, Chicago, Ill.

Roger H. Lehman, MD, Milwaukee
Associate Professor and Acting Chairman, Department of Otolaryngology, Marquette School of Medicine

Robert W. Edland, MD, Madison
Assistant Professor of Radiology (Radiotherapy), University of Wisconsin Medical School

James H. Brandenburg, MD, Madison
Associate Professor of Surgery, University of Wisconsin Medical School

4. SURGERY

MILWAUKEE COUNTY HOSPITAL

8:00 to 12:00—WET CLINIC

Moderator: JOHN T. MENDENHALL, MD, Madison
President, Wisconsin Surgical Society

This is part of the all-day program of the Wisconsin Surgical Society and nonmember guests are welcome.

12:30—SCIENTIFIC LUNCHEONS

HOTEL SHERATON–SCHROEDER

1. INTERNAL MEDICINE

DIFFICULT PROBLEMS OF KIDNEY DISEASE

Weldon D. Shelp, MD, Madison
Assistant Professor of Medicine, University of Wisconsin Medical School

PARLOR B: FOURTH FLOOR

2. INTERNAL MEDICINE

OPPORTUNITIES FOR PHYSICIANS IN THE WISCONSIN REGIONAL MEDICAL PROGRAM

John S. Hirschboeck, MD, Milwaukee
Program Coordinator, Wisconsin Regional Medical Program, Inc.

PARLOR E: FOURTH FLOOR

3. PLASTIC SURGERY

EMERGENCY CARE OF THE INJURED FACE

Frank D. Bernard, DDS, MD, Madison
Clinical Professor of Surgery, University of Wisconsin Medical School

PARLOR C: FOURTH FLOOR

4. ORGAN TRANSPLANTATION

KIDNEY TRANSPLANTATION

H. M. Kauffman, Jr., MD, Milwaukee
Assistant Professor of Surgery, Marquette School of Medicine

PARLOR D: FOURTH FLOOR

5. ANESTHESIA

HYPERBARIC OXYGENATION

Edgar End, MD, Milwaukee
Director, Milwaukee County Hyperbaric Unit

PARLOR A: FOURTH FLOOR

6. ORTHOPEDICS

A SECOND LOOK AT THE EARLY TREATMENT OF CLUB FEET

William S. Smith, MD, Ann Arbor, Mich.

Chairman: FREDERICK G. GAENSLEN, MD, Milwaukee

ENGLISH ROOM: FIFTH FLOOR

7. OTOLARYNGOLOGY & PEDIATRICS

Special luncheon: EAST ROOM, HOTEL SHERATON–SCHROEDER

Presented by the Sections on Otolaryngology and Pediatrics

PANEL: ADVISABILITY OF T. AND A. IN SINUS DISEASE AND HEARING DISORDERS

Moderator: JOHN K. SCOTT, MD, Madison
Associate Clinical Professor of Surgery, University of Wisconsin Medical School

Participants:

Donald P. Babbitt, MD, Milwaukee
Director, Department of Radiology, Milwaukee Children's Hospital; Associate Professor of Radiology, Marquette School of Medicine

Howard C. High, MD, Milwaukee
Assistant Clinical Professor of Otolaryngology, Marquette School of Medicine

Henry Rikkers, MD, Madison
Assistant Professor of Pediatrics, University of Wisconsin Medical School

8. OPHTHALMOLOGY

Chairman: RICHARD W. ASHLEY, MD, Kenosha

No speaker. Business meeting to follow.

PERE–MARQUETTE ROOM: FIFTH FLOOR

AFTERNOON SCIENTIFIC PROGRAMS

HOTEL SHERATON–SCHROEDER AND MILWAUKEE AUDITORIUM

FIVE PROGRAMS RUNNING CONCURRENTLY: Ophthalmology, Otolaryngology, Anesthesiology, Orthopedics, and Surgery

1. OPHTHALMOLOGY

EAST ROOM, HOTEL SHERATON–SCHROEDER

Chairman: RICHARD W. ASHLEY, MD, Kenosha
Chairman, Section on Ophthalmology of SMS

2:00—RECENT ADVANCES IN OPHTHALMIC PLASTIC SURGERY

Alston Callahan, MD, Birmingham, Ala.
President, The Eye Foundation, Inc.

3:00—CLINICOPATHOLOGICAL CONFERENCE

Harry A. Easom, MD, Milwaukee
Assistant Clinical Professor of Ophthalmology, Marquette School of Medicine

2. OTOLARYNGOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

2:00—BUSINESS MEETING

Section on Otolaryngology

Chairman: JOHN K. SCOTT, MD, Madison

2:30—SURGERY FOR RECURRENT CARCINOMA AFTER LARYNGECTOMY

George A. Sisson, MD, Chicago, Ill.
Department of Otolaryngology and Maxillofacial Surgery, Northwestern University Medical School

Chairman: CHARLES R. TABORSKY, MD, Madison

3:00—RECESS TO VIEW EXHIBITS

3:30—BUSINESS MEETING

Wisconsin Society of Otolaryngology

Chairman: CHARLES R. TABORSKY, MD, Madison
President, Wisconsin Society of Otolaryngology

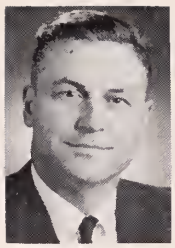
3. ANESTHESIOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Chairman: ROBERT M. SCHUYLER, MD, Milwaukee
President, Wisconsin Society of Anesthesiologists

2:00—THE ANESTHESIOLOGIST AND INHALATION THERAPY IN THE PRIVATE HOSPITAL

Jergen L. Barber, MD, Waukesha
Medical Director, Department of Inhalation Therapy, Waukesha Memorial Hospital



BEAHRS

CALLAHAN

2:30—PROBABLE SITE OF ACTION OF HALOTHANE IN A MODEL MEMBRANE PREPARATION

Claude A. Taylor, MD, Madison
Associate Professor of Anesthesia, University of Wisconsin Medical School

3:00—RECESS TO VIEW EXHIBITS

3:30—INTRAVENOUS REGIONAL BLOCKS

Robert E. Holzgrafe, MD, Milwaukee
Clinical Instructor in Anesthesiology, Marquette School of Medicine

4:00—BUSINESS MEETING

Section on Anesthesiology of SMS

4. ORTHOPEDICS

WALKER HALL, MILWAUKEE AUDITORIUM

Chairman: FREDERICK G. GAENSLEN, MD, Milwaukee

2:00—SCOLIOSIS: THE IMPORTANCE OF PROMPT RECOGNITION AND TREATMENT

Walter P. Blount, MD, Milwaukee
Clinical Professor of Orthopedic Surgery, Emeritus, Marquette School of Medicine

3:00—RECESS TO VIEW EXHIBITS

3:30—THE PATTERNS AND MECHANISMS OF LUMBAR SPINE INJURIES ASSOCIATED WITH LAP-TYPE SEAT BELTS

William S. Smith, MD, Ann Arbor
Professor and Head, Section of Orthopedic Surgery, University of Michigan

5. SURGERY

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Chairman: JOHN T. MENDENHALL, MD, Madison
President, Wisconsin Surgical Society

1:45—DOCTOR F. GREGORY CONNELL, OUR FIRST PRESIDENT

Louis D. Graber, MD, Oshkosh

THURSDAY *continued*

2:05—HEPATIC SUPPORT SYSTEMS: PRESENT AND FUTURE

Joseph C. Darin, MD, Milwaukee
Professor of Surgery, Marquette School of Medicine

2:25—BILE, BACTERIA, AND BILIARY DISEASE

John T. Goswitz, MD, Manitowoc

2:40—THE AGGRESSIVE SURGICAL APPROACH TO CORONARY DISEASE

W. Dudley Johnson, MD, Milwaukee
Assistant Professor of Surgery, Marquette School of Medicine

3:00—RECESS TO VIEW EXHIBITS

3:20—THE VALUE OF RADICAL NECK DISSECTION IN THE MANAGEMENT OF HEAD AND NECK CANCER

Oliver H. Beahrs, MD, Rochester, Minn.
Professor of Surgery, Mayo Graduate School of Medicine, University of Minnesota

3:50—TO MAMMOGRAM OR NOT—FIVE-YEAR PRACTICAL EXPERIENCE

William B. Hobbins, MD, Madison
Assistant Clinical Professor of Surgery, University of Wisconsin Medical School

4:05—PANEL DISCUSSION: HEAD AND NECK LESIONS

Moderator: ROBERT O. JOHNSON, MD, Madison
Associate Professor of Clinical Oncology, University of Wisconsin Medical School

4:35—PRESIDENTIAL ADDRESS

Kenneth L. Carter, MD, Beloit
Beloit Clinic

BUSINESS MEETING
Wisconsin Surgical Society

EVENING PROGRAMS

6:30—DINNER: Wisconsin Surgical Society

Milwaukee Athletic Club

Speaker: OLIVER H. BEAHRS, MD, Rochester, Minn.

6:30—DINNER: Wisconsin Orthopaedic Society

Milwaukee Athletic Club

Chairman: FREDERICK G. GAENSLEN, MD, Milwaukee
President, Wisconsin Orthopaedic Society

Speaker: WILLIAM S. SMITH, MD, Ann Arbor, Mich.

Topic: *Long-term Evaluation of Congenital Dislocation of the Hip*

6:30—DINNER: Milwaukee Ophthalmological Society

(All ophthalmologists and interested physicians welcome)

University Club

Speaker: ALSTON CALLAHAN, MD, Birmingham, Ala.

Chairman: BRIAN C. McLAUGHLIN, MD, Milwaukee
President, Milwaukee Ophthalmic Society

MAKE YOUR HOTEL RESERVATIONS NOW

STATE MEDICAL SOCIETY OF WISCONSIN
MAY 13 - 15, 1969

PLEASE CHECK ACCOMMODATIONS DESIRED
All rates subject to 3% state tax + 3% Room Tax.

1 PERSON — SINGLE OCCUPANCY ☐ 14.00 ☐ 15.50 ☐ 12.50 ☐ 11.00

2 PERSONS — DOUBLE OCCUPANCY ☐ 19.00 ☐ 20.50 ☐ 17.50

1 BEDROOM SUITE ☐ 35.00 2 BEDROOM SUITE ☐ 56.00

No Charge for Children Occupying Room with Parents.

Arrival Date _____ Specify Arrival Time _____ Departure Date _____

NAME _____ NO. OF PERSONS PER ROOM _____

STREET _____

CITY _____ STATE _____ ZIP _____

Next higher rate will be confirmed if accommodations requested are unavailable.
Rooms will be held until 6 p.m. unless otherwise specified.

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RESERVATION FORMS FOR

Noon Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 2 Choices for each of the days you make reservations. List in order of preference. $3.50 per luncheon, including gratuities and taxes.

TUESDAY, MAY 13 (See page 11 for listing)

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. MEYER: Recent Advances in Drug Therapy
2. MANIER: Some Current Misconceptions—Gastrointestinal Disease
3. RIESELBACH: Management of the Patient with Chronic Renal Failure
4. SLACK: Computer-Based Medical Interviewing
5. WITEBSKY: Immunology Today and Its Potential for Tomorrow
6. WAGNER: Current Studies of Pulmonary Embolism
7. HANDY: Comprehensive Health Planning As It Relates to Wisconsin
8. LEPLEY: Organ Transplantation—Present and Future

Name of Leader: *Name of Leader*

First Choice: _____ Second Choice: _____

WEDNESDAY, MAY 14 (See page 15 for listing)

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. MIDDLETON: Some Promising Therapeutic Advances in Neuropsychiatric Disorders
2. RICE: Symposium on Sexual Attitudes and Marriage Counseling; KRANTZ: A Matriarchal Society—Its Problems
3. EICHMAN: The Modern Medical Center As An Adjunct to Neurological Practice
4. SCHORR: Contact Dermatitis—Practical Office Management
5. FARR: The Changing Concept of Allergy
6. JOHNSON: The Present State of Direct and Indirect Myocardial Revascularization
7. GAARDER–MILLER, INC.: Improved Efficiency in Office Practices
8. ALPERT: Poison Control—Why the Fuss?

Name of Leader: *Name of Leader*

First Choice: _____ Second Choice: _____

THURSDAY, MAY 15 (See page 19 for listing)

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. SHELP: Difficult Problems of Kidney Disease
2. HIRSCHBOECK: Opportunities for Physicians in the Wisconsin Regional Medical Program
3. BERNARD: Emergency Care of the Injured Face
4. KAUFFMAN: Kidney Transplantation
5. END: Hyperbaric Oxygenation
6. SMITH: A Second Look at the Early Treatment of Club Feet
7. SCOTT; BABBITT/HIGH/RIKKERS: Panel—Advisability of T. and A. in Sinus Disease and Hearing Disorders
8. OPHTHALMOLOGY: No speaker

Name of Leader: *Name of Leader*

First Choice: _____ Second Choice: _____

ANNUAL DINNER, Wed., May 14

ENTERTAINMENT—COCKTAILS
SHORT SPEECHES—

$10.00 PER PERSON (Including Gratuities and Taxes)

Number Luncheon Tickets ($3.50 each) . . . . _____ for $_____

Number Annual Dinner Tickets ($10.00 each) . . _____ for $_____ TOTAL $_____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ STREET _____ CITY _____
(Print, please)

MAIL TO: State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701

Scientific Exhibits

MILWAUKEE AUDITORIUM

EXHIBIT HOURS

Tuesday, May 13 _____ 8:00 am–5:00 pm
Wednesday, May 14 _____ 8:30 am–5:00 pm
Thursday, May 15 _____ 8:30 am–3:45 pm
(Exhibits "break up" at 3:45 pm on Thursday, May 15)

S-1—SERVICES OF REGIONAL MEDICAL PROGRAM TO THE PRACTICING MD

Wisconsin Regional Medical Program: Mr. Roy T. Ragatz; Thomas C. Meyer, MD; Mrs. Barbara Mulvihill; in cooperation with the University of Wisconsin Extension Division and Marquette School of Medicine

Special attention will be directed to the Dial Access Library phone service, and the Single Concept film serviee available to medical staffs of Wisconsin hospitals. The exhibit also will provide information on additional WRMP funded projects which will provide educational experiences for practicing physicians in the state.

S-2—PREVENTION THROUGH EDUCATION

Wisconsin Heart Association, Milwaukee

Platform, canopy, and three mechanically-driven panels with information on three future professional medical programs and an assortment of literature for physicians and their patients.

S-3—WE HAVE STOPPED SMOKING

Bureau of Community Health Services, State Division of Health, Madison

An exhibit consisting of three panels which are illuminated from overhead by four lamps. Panels are hinged together. Message is directed at physicians and allied medical professions.

S-4—ULTRASTRUCTURAL DEVELOPMENT OF MYOCARDIAL BINDING SITES IN THE FETAL RHESUS MONKEY

James R. Allen, MD and L. A. Carstens, Primate Research Center, in cooperation with the University of Wisconsin Medical School, Department of Pathology

Ventricular myocardial cells form 60 fetal rhesus monkeys were examined electron microscopically. Between the 25th and 65th days of gestation the pleomorphic, randomly dispersed myocardial cells were attached by short desmosomes. These binding sites consisted of inner and outer leaflets of the sarcolemma surrounded by an electron dense desmosomal plaque. The two portions of the desmosome were separated by a moderately electron opaque intercellular space. As the myocardial cells progressed in age, they became more closely associated and assumed a rcetangular outline. Desmosomal binding sites increased in number. The first identifiable intercalated disc consisted of short desmosomes, regions of unmodified sarcolemma, and long, diffuse, myofilament-associated attachment sites. A nexus was formed by contiguous cells at each end of the disc. Fine structural features of the desmosome portion of the disc were similar to those in the younger tissue. The filament-associated portion was composed of a wide lateral zone of condensed sarcoplasm that contained a network of fine filaments. Inner and outer leaflets of the sarcolemma were discernible and the intercellular space was uniform in width. Initially, the intercalated discs were relatively straight; however, as the cells matured, they assumed a sinuous profile.

S-5—MEDICAL SELF-HELP TRAINING

James Joyce, Medical Self-Help Consultant, Section of Emergency Health Services, Division of Health, State Department of Health and Social Services, Madison

Medical Self-Help is a program designed to provide information and training that will help prepare people for survival in a time of a natural or national disaster when the services of a physician or other allied health personnel are not available. Illuminated with panel background—film viewing daylight projector—continuous telestory slide presentation.

S-6—FOOD SERVICE PERSONNEL TRAINING INSTITUTE

Roy K. Clary and Kenneth K. Thiede, in cooperation with the State Division of Health, Hotel Restaurant Section

This exhibit consists of training of personnel in food handling with special interest in bacteriologic slides.

S-7—CANCER EDUCATION

American Cancer Society, Milwaukee Division and Wisconsin Division

The American Cancer Society exhibit, cosponsored by the Milwaukee and Wisconsin Divisions, will provide the latest information on diagnosis and treatment of cancer through the use of films and literature. In addition, the exhibit will have on display materials considered "Public Education" which is available to physicians for use in their reception rooms.

S-8—HAIR LOSS: DIFFERENTIAL DIAGNOSIS

H. R. Foerster, Jr., MD, R. J. Scrimenti, MD and T. Russell, MD, in cooperation with Columbia Hospital, Milwaukee

A brief outline of differential diagnosis of alopecia is presented which is followed by a series of clinical transparencies. Each photograph has an associated comment suggesting the significant clinical features and also the diagnosis, which is covered by a flap by which a physician can compare his diagnosis with the photograph.

S-9—HYPERLIPIDEMIA, DIAGNOSIS AND TREATMENT

R. B. Pittelkow, MD, D. D. Klink, MD, and R. L. Arends, PhD, in cooperation with Columbia Hospital, Milwaukee

Since the publication of Frederickson's classification of hyperlipidemias—based upon the determination of cholesterol, triglycerides, and lipoprotein fractionation—the maladies in this category have come increasingly to the forefront of clinical attention. Their techniques are available to every practicing physician either in his own or a commercial laboratory. A demonstration will be given of their application to specific cases of hyperlipidemia, the resultant classification and response to therapy. Photographs will be provided of pertinent physical signs, lipemic serum, lipoprotein fractionation patterns, and microscopic findings. An outline of method-

ology, case classification, and pertinent bibliography will be provided so that any interested physician may take a copy with him.

S-10—SURGICAL TREATMENT OF DEGENERATIVE HIP DISEASE

W. P. Blount, MD, R. H. Cassidy, MD, and R. C. Zuege, MD, in cooperation with Columbia Hospital, Milwaukee

Several surgical techniques used in the treatment of degenerative hip disease will be presented, with indications for each type. Case histories, with x-rays and diagrams will be used. Techniques included will be proximal osteotomy, endoprosthesis, arthrodesis, and total hip replacement.

S-11 & 12—THE NON-OPERATIVE TREATMENT OF SCOLIOSIS AND ROUND BACK WITH THE MILWAUKEE BRACE, AND EXERCISES IN THE BRACE

Walter P. Blount, MD, Richard G. Bidwell, CO, and Bernard Huizenga, MD, in cooperation with Marquette School of Medicine and Milwaukee Children's Hospital

Descriptive material and illustrations will demonstrate the method of fabrication of the brace. Before and after photographs and x-rays will illustrate the results of treatment of scoliosis and round back with the Milwaukee brace and exercises in the brace. The various curve patterns will be shown. In order to obtain the best results the diagnosis must be made early and the treatment started promptly. The brace and exercises must be continued until the patient is completely mature.

S-13—SWALLOWING OF FOREIGN BODIES BY CHILDREN

Donald P. Babbitt, MD, Thomas T. Tang, MD, and Samuel R. McCreadie, MD in cooperation with Milwaukee Children's Hospital

This exhibit consists of 100 objects removed from the alimentary tracts of children, and radiological identification and location of these objects.

S-14 & 15—WISCONSIN SOCIETY OF PATHOLOGISTS

Gordon E. Lang, MD, Wisconsin Society of Pathologists

The Wisconsin Society of Pathologists this year will expand upon last year's exhibit and offer to physicians in attendance a comprehensive chemical and hematologic survey. Educational material will be provided. A pathologist will be in attendance at all times to help answer questions.

S-16—INTRAUTERINE CONTRACEPTIVE DEVICE

Herbert F. Sandmire, MD and Stephen D. Austin, MD, in cooperation with the Beaumont Clinic, Green Bay

Illustrates experience with 400 patients using intrauterine contraceptive devices. Included will be illustrations of insertion technique, criteria for selection of patients, and tabulation of complications. In addition, patient acceptance and follow-up techniques will be outlined. The reasons for discontinuing the use of the device, including undesired pregnancy, are tabulated. Hand out sheets summarizing our study will be available to physicians visiting the exhibit.

S-17 & 18—FAMILY PLANNING—A BASIC HUMAN RIGHT

Roland S. Cron, MD, Chairman of the Medical Advisory Committee, Planned Parenthood Association of Milwaukee, in cooperation with the Planned Parenthood Association

Exhibit describes world population growth and the role of Planned Parenthood-World Population in its quest to make safe, effective means of family planning available to families throughout the world. Educational materials describe latest contraceptive research, current methods of birth control, family life and sex education resources, premarital education and counseling on infertility. Local Planned Parenthood program offers sex education, premarital counseling, child-spacing clinics, medical research, and orientation and training for professionals. Medical clinics staffed by specialists in obstetrics and gynecology, registered nurses, and social workers.

S-19—WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

Wisconsin State Medical Assistants Society

A traveling exhibit on the Certification Program developed by Merck, Sharp & Dohme. This program was established by the AAMA to help physicians identify top level assistants, administrative and/or clinical and to establish standards and goals for medical assistants.

S-20—SURGERY FOR CORONARY DISEASE

W. Dudley Johnson, MD, Derward Lepley, Jr., MD, John Huston, MD, John Walker, MD, John Manley, MD, Henry Gale, MD, and H. David Friedberg, MD, in cooperation with Marquette School of Medicine, St. Luke's Hospital, Milwaukee and Wood, VA Hospital

In the past two years, 240 patients have undergone surgery for coronary disease. Surgery has been refused to less than 2% of symptomatic patients regardless of age or severity of symptoms. Numerous "end stage" patients have been operated successfully, the type often subjected to transplants elsewhere. This display illustrates the combined approach used for nearly all coronary patients: (1) resection of all ventricular aneurysms, (2) the direct reconstruction of coronary flow in over 90% of patients with single or double vein bypass grafts to any coronary artery or arteries, and (3) indirect revascularization with four to nine separate arterial implants reaching all areas of the left ventricle. Two or three simultaneously performed procedures are done in nearly all. This approach has offered new hope for the end-stage coronary patient. Operative techniques, results, and illustrative cases will be displayed, along with the techniques which have been developed to support and manage the advanced coronary patient through surgery.

S-21—VALVES OF THE RENAL AND GONADAL VEINS

James W. Pick, MD, in cooperation with St. Anthony Hospital, Milwaukee

Anatomic analysis of location, numbers and types of valves located in the renal and gonadal veins of 120 cadavers. Distribution of the valves is explained on the basis of genesis of valves prior to 6-month foetal age, with no valves formed thereafter. Relation of distribution of the valves in the renal veins of the two sides is explained completely by the bilaterality of the postrenal inferior vena cava in the early foetus, with great tendency for the left postrenal vena cava to disappear with further development. Relation of the migration of the testes and ovaries to the simultaneous migration of the valves in the pampiniform plexuses is explained with the lengthening of the retroperitoneal distal half of the internal spermatic (or ovarian) veins with no new valves

forming in these segments. Conjecture as to function of the foetal renal venous valves is offered, versus the often vestigial appearance of the valves in adult cadavers.

S-22 & 23—DIAGNOSTIC APPROACH TO ABDOMINAL MASSES IN CHILDREN

Samuel R. McCreadie, MD, Donald P. Babbitt, MD, Marvin Glicklich, MD, Shimpei Sakaguchi, MD, L. Gilbert Thatcher, MD, and C. Randolph Turner, in cooperation with Milwaukee Children's Hospital

Given an abdominal mass in a child, what are the steps necessary to reach a diagnosis? This exhibit will outline recommended steps and procedures needed to make the diagnosis definite enough for specific and effective treatment. Before definitive treatment is undertaken, full discussion by the Tumor Board and all physicians involved is a vital step in evaluation, planning, and management. Since many of these masses are malignant, it is our experience that cooperation between physician, surgeon, radiologist, pathologist, and chemotherapist has been of great benefit to all, especially the patient. A step-by-step approach will be presented. It is planned to include the showing of slides in the exhibit.

S-24—ATRIAL SEPTAL DEFECT, DIAGNOSIS AND TREATMENT

Allen J. Pois, MD, Department of Cardiovascular Surgery; John Morledge, MD, Department of Internal Medicine; Gordon A. Tuffli, MD, Department of Pediatrics; Peter Rank, MD, Department of Radiology, in cooperation with the Jackson Clinic and Methodist Hospital, Madison

This exhibit will feature the clinical diagnosis and management of interatrial septal defect, with special emphasis on the lesion in the adolescent and adult patient. The incidence, prognosis, and physical findings of atrial septal defect will be presented, as well as the characteristic x-ray and electrocardiographic features of the disease. Characteristic auscultatory findings will be presented by means of instructional heart sound recordings, and the diagnostic and prognostic value of cardiac catheterization will be shown. Surgical correction of atrial sepal defect will be reviewed, with emphasis on modern cardiopulmonary bypass techniques. Visual aids will include illuminated reproductions of ECGs, chest x-rays, and diagnostic cardiac laboratory and surgical procedures.

S-25—EFFECTS OF ANESTHESIA AND SURGICAL OPERATIONS ON RESPIRATORY FUNCTIONS

Nancy Wu, MD, Nalda Thung, MD and Karl L. Siebecker, MD, in cooperation with the University of Wisconsin Medical Center, Department of Anesthesiology, Madison

Respiratory function is affected in many ways during anesthesia and surgical operations. All general anesthetic agents, as well as some pre-anesthetic medications, depress the respiratory center and render it less sensitive to carbon dioxide. Airway resistance can be increased by multiple factors causing obstruction from the oral cavity down to the lung. The distensibility of the lung and chest wall is affected by external forces exerted on the chest and the lung and by many other causes which interfere with the expansion. The cardiocirculatory effect of anesthesia and surgical intervention produces change of pulmonary perfusion and the efficiency of the transport system. Either one of these factors alone or combined may contribute to respiratory decompensation. Possible detrimental effects which occur under these circumstances, if not corrected, may well extend into the postoperative period. We are presenting in this exhibit, the multiplicity of possible disturbances of respiratory function during anesthesia and surgical operations, with the purpose of intensifying the awareness of these problems in the care of surgical patients.

S-26 & 27—TOXICITY OF LOCAL ANESTHETIC AGENTS AND NEWER CONCEPTS IN MANAGEMENT

Ettore Di Miceli, MD, in cooperation with St. Joseph's Hospital, Milwaukee

The exhibit will illustrate the signs and symptoms of toxicity caused by local anesthetic agents and present the newer concepts in the management of toxic reactions to these agents. The exhibit will also give the clinician the opportunity to test his own knowledge of the safe dosage range of commonly used local anesthetics.

S-28–29—PARABEN ALLERGY: A SUBTLE CAUSE OF INTRACTABLE DERMATITIS CAUSED BY DERMATOLOGIC AND COSMETIC CREAMS AND LOTIONS

William F. Schorr, MD, Department of Dermatology, Marshfield Clinic, in cooperation with the Marshfield Clinic and Marshfield Clinic Foundation for Medical Research and Education

This exhibit received the S. William Becker Gold Award at the American Academy of Dermatology, December 1968. It demonstrates the mechanism of proper testing for paraben allergy. Parabens are found in almost all cosmetic and therapeutic corticosteroid creams. If this diagnosis is missed, no matter what cream or lotion a doctor applies, the dermatitis continues to flare. Several years ago we reported the first case of paraben allergy to be diagnosed in the U.S. and we now have five cases of paraben allergy. The exhibit shows colored photographs before and after treatment together with the mechanism of making a diagnosis.

S-30—FILM DOSIMETRY IN RADIATION THERAPY

Maurice Greenberg, MD, Charles Lescrenier, BA, Assistant Professor Biophysics in Radiology, Arnold Sorensen, and Marian Storbakken, in cooperation with Marquette School of Medicine

Radiation therapy dosimetry using film is simplified by the use of the plane densitometer; a working model is exhibited. Its principal feature is its ability to quickly and accurately determine photographic isodensity patterns. The exhibit illustrates its operation based on the diffusion transfer photocopy principle. Isodensity patterns or shapes are normalized to dose values as measured by ionization chambers or solid state radiation detectors. The validity of the density shape is tested by exposure to multiple secondary detectors such as lithium flouride dosimeters. Some applications are as follows: (1) to determine x-ray and gamma beam shapes produced by teletherapy equipment, (2) to determine the shape of electron beams used in therapy, (3) to investigate the effects of radiation intensities by types of tissue, (4) relative comparisons of dose calibrations between two therapy departments, (5) plot radiation fields around radioactive sources implanted in patients, and (6) quantitative evaluations of roentgenograms.

S-31—THE BRAIN STEM OF THE CAT

Alvin L. Berman, PhD, Associate Professor of Anatomy, University of Wisconsin, in cooperation with the University of Wisconsin Medical School, Madison

Plates of photomicrographs of frontal, sagittal, and horizontal sections of the brain stem of the cat illustrate the cellular architecture of this region in a mammal used extensively in experimental investigations.

S-32—SUPRAPUBIC CATHETER DRAINAGE

W. E. Martens, MD, F. J. Hofmeister, MD and R. Strebel, MD, in cooperation with Lutheran Hospital of Milwaukee, Inc.

Suprapubic drainage of the bladder following cystourethrocele repair or when extended bladder drainage may be required is demonstrated. Pictures depict materials and the technique employed. Insertion of the small drainage tube is demonstrated by a movie. Advantages over conventional Foley catheter drainage are patient comfort and a reduction in required nursing care. Exacting instruction and proper patient understanding will reduce urinary retention and encourage early voiding.

S-33—RENAL CYST PUNCTURE

T. H. McDonell, MD, F. A. Thompson, MD, F. C. Feulner, MD, and A. M. Richter, MD, in cooperation with Waukesha Memorial Hospital

(1) A simple and conclusive diagnostic examination which can remove doubts about accuracy in roentgen diagnosis. (2) A simple conclusive diagnostic study which can obviate surgery in doubtful cases.

S-34—THE USES OF PULMONARY ARTERIOGRAPHY

Richard D. Sautter, MD and Thomas G. Olsen, MD, in cooperation with the Marshfield Clinic Foundation for Medical Research and Education, Marshfield

The various uses of pulmonary arteriography will be displayed and will include pulmonary A-V fistula, pulmonary emphysema, pulmonary artery aneurysm, carcinoma of the lung, pulmonary thromboembolism, and total anomalous venous drainage. There will also be with the exhibit a movie showing the technique of pulmonary arteriography.

S-35—WATER BREATHING

Edgar End, MD and R. Bachand, Department of Environmental Medicine, Marquette School of Medicine, Milwaukee

Small animals will be kept alive beneath the surface of water in a small pressure chamber, breathing the water and effecting adequate exchange between their blood and aqueous environment. This is possible by keeping the water saturated with oxygen under pressure and by the use of buffers to control carbon dioxide. Such studies are bringing increased knowledge of the lung in intrauterine life and in such conditions as hyaline membrane disease. In addition, this exhibit reaffirms the basic principles of diffusion governing all respiration.

28—COMMON OCULAR PROBLEMS OF THE FAMILY PHYSICIAN

M. D. Davis, MD, G. W. Harris, MD, R. M. Levy, MD, and O. Hermundstad, MD, in cooperation with the University of Wisconsin Hospitals, Division of Ophthalmology, Madison

Stereoscopic photographic slides in stereoscopic viewers demonstrating corneal foreign bodies, drug reactions, cataracts, stabismus, diabetic retinopathy, hypertensive retinopathy.

29—CORNEAL DISEASE AND SURGERY OF THE CORNEA

Rodney J. Sturm, MD and John V. Berger, Jr., MD, in cooperation with the University of Wisconsin, Department of Surgery (Ophthalmology), Madison

An explanation of how to acquire donor material will be given as well as a discussion of the various corneal diseases. Surgical application to certain of these diseases will be discussed as well.

30—GAIT TRAINING IN HEMIPLEGIA

Basilio Lopez, MD and P. Thielen, RPT, Department of Physical Medicine & Rehabilitation of Sacred Heart Rehabilitation Hospital, Milwaukee

A graphic study of pathological gait in hemiplegia will be presented with a concentration on corrective procedures. An outline for planning the approach to treatment will be included and bracing the spastic lower extremity will be covered. A supplement on the short leg brace will also be included.

31—MECHANISM OF SPLIT CRANIAL SUTURES IN METASTATIC NEUROBLASTOMA

T. L. Carter, MD and T. O. Gabrielsen, MD, in cooperation with the University of Michigan and Madison General Hospital

Skull metastases and split cranial sutures frequently occur in patients with neuroblastoma. Typical examples of ten autopsy-proven cases are presented to demonstrate the pattern of cranial and intracranial metastases. Deposits of neuroblastoma involving the calvarium are usually continuous with subperiosteal and extradural metastases, which may be very bulky. The dura mater seems to act as a barrier to the deeper penetration of the tumor. The brain is rarely, if ever involved with neoplasm. The dural venous sinuses are ordinarily patent. It appears that split cranial sutures act chiefly as a mechanism for accommodating bulky extradural metastases.

32—NATURAL CHILDBIRTH ASSOCIATION OF MILWAUKEE

Natural Childbirth Association, Milwaukee

The Natural Childbirth Association of Milwaukee offers an educational program to prepare parents for the childbirth experience. Through training in breathing techniques, relaxation, and an understanding of the birth process, parents are prepared to actively participate in labor and delivery. In addition to our primary goal of parent education, the NCA strives to serve the community through several programs. The training our class members have received and the importance of the nurses support for a good childbirth experience are presented at our inservice classes for Milwaukee area nursing students. We tailor a preparation for childbirth class to the needs of the unwed mother at Booth Memorial Home and Rosalie Hall. We participated in the Prenatal Education Project for the Inner City–North by training their instructors to teach the breathing techniques, relaxation, and exercises taught in our classes. We believe in early prenatal care and complete cooperation with the decisions of the physician. Our classes are taught in seven hospital locations through the city and class members must have the written approval of their physician to attend class.

48—THE BADGER RED CROSS BLOOD PROGRAM

Badger Red Cross Regional Blood Center, Madison

Technical Exhibits

(An incomplete listing at this date)

81—ABBOTT LABORATORIES, North Chicago, Ill.
83—APACHE OIL PROGRAMS, INC., Minneapolis, Minn.
37—ARNAR–STONE LABORATORIES, INC., Mount Prospect, Ill.
66—ASTRA PHARMACEUTICAL PRODUCTS, INC., Worcester, Mass.
62—AYERST LABORATORIES (Division of American Home Corp.), New York, N. Y.

64—BEECHAM RESEARCH LABORATORIES, New York, N. Y.
97—BORDEN PHARMACEUTICAL DIVISION, New York, N. Y.
86—BRISTOL LABORATORIES, Syracuse, N. Y.
96—BURROUGHS WELLCOME & COMPANY, INC., Tuckahoe, N. Y.

71—CIBA PHARMACEUTICAL COMPANY, Summit, N. J.
50—COCA COLA USA, Atlanta, Ga.

12—EATON LABORATORIES, Norwich, N. Y.
24—ECONO LEASE, INC., Milwaukee
38—THE EMKO COMPANY, St. Louis, Mo.
17—ENCYCLOPAEDIA BRITANNICA, Chicago, Ill.

20—GORDON FLESCH COMPANY, Madison
36—FLINT DIAGNOSTICS, Morton Grove, Ill.
87—FLINT LABORATORIES, Morton Grove, Ill.

90—HANDICABS OF MILWAUKEE, Milwaukee
93—HOECHST PHARMACEUTICALS, INC., Cincinnati, O.

5—LAKESIDE LABORATORIES, INC., Milwaukee
35—LANGER LABORATORIES, INC., Milwaukee
3—LEDERLE LABORATORIES, Pearl River, N. Y.
10—J. B. LIPPINCOTT COMPANY, Philadelphia, Pa.
40—LOMA LINDA FOODS, Riverside, Calif.

55—MARION LABORATORIES, Kansas City, Mo.
56—MEAD JOHNSON LABORATORIES, Evansville, Ind.
72—MEDICAL PROTECTIVE COMPANY, Fort Wayne, Ind.
1—MEDICO–MART, INC., Milwaukee
95—THE C. V. MOSBY COMPANY, St. Louis, Mo.
9—MUTUAL BENEFIT LIFE INSURANCE COMPANY, Madison

54—PARKE, DAVIS & COMPANY, Detroit, Mich.
6—PROFESSIONAL BUSINESS SERVICE, La Crosse
52—PROGRAMMED LEARNING, INC., Garden City, N. J.

58—WILLIAM H. RORER, INC., Fort Washington, Pa.
33—ROSS LABORATORIES, Columbus, O.
84—ROWELL LABORATORIES, INC., Baudette, Minn.

63—W. B. SAUNDERS COMPANY, Philadelphia, Pa.
11—SCHERING LABORATORIES, Union, N. J.
74—G. D. SEARLE & COMPANY, Chicago, Ill.
59—SEEFURTH & MC GIVERAN, Milwaukee
8—SMITH KLINE & FRENCH LABORATORIES, Philadelphia, Pa.
51—SMITH, MILLER & PATCH, INC., New York, N. Y.
65—SWIFT & COMPANY, Chicago, Ill.

15—UNITED MEDICAL LABORATORIES, INC., Portland, Ore.
89—The UPJOHN COMPANY, Kalamazoo, Mich.

75—WARNER–CHILCOTT LABORATORIES, Morris Plains, N. J.
53—WINTHROP LABORATORIES, New York, N. Y.
21–22—WISCONSIN BLUE SHIELD—WPS, Madison
57—WISCONSIN 7-UP BOTTLERS
78—WYETH LABORATORIES, Philadelphia, Pa.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1969 WISCONSIN

Apr. 25–26: Annual meeting, Wisconsin Urological Society, Holiday Inn—Mid Town, Milwaukee.

May 1: Jackson Clinic and Foundation Spring Postgraduate Meeting, Park Motor Inn, Madison.

May 5–7: Annual session, Wisconsin State Dental Society, Milwaukee Auditorium, Milwaukee.

May 7: Projected Clinics, Wisconsin State Dental Society.

May 11: State Medical Society Council meeting, Hotel Sheraton–Schroeder, Milwaukee.

May 12–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 14: State Medical Society Council meeting, Hotel Sheraton–Schroeder, Milwaukee.

May 14–16: Annual Conference, National Society for the Prevention of Blindness, Pfister Hotel, Milwaukee.

May 15: Annual Meeting, Wisconsin Surgical Society, in conjunction with the Annual Meeting of the State Medical Society of Wisconsin, Milwaukee.

June 5–7: Conference on "The New Hospital Psychiatry," sponsored by the University of Wisconsin Department of Postgraduate Medicine, Department of Psychiatry, and the Wisconsin Psychiatric Institute of the University of Wisconsin Medical Center, Madison.

June 9: UW graduation day.

June 15: President's Reception, State Medical Society, Madison.

Aug. 2–3: State Medical Society Council meeting.

Sept. 11–14: Annual Meeting, Wisconsin Society of Internal Medicine, Deer Park Lodge, Land O'Lakes.

October: Wisconsin Work Week of Health, State Medical Society, Madison.

Oct. 8–9: Annual meeting, Wisconsin Academy of General Practice, Holiday Inn No. 2, Madison.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton–Schroeder Hotel, Milwaukee.

1969 NEIGHBORING STATES

Apr. 11–13: Annual meeting, National Association of Blue Shield Plans, Chicago, Ill.

Apr. 14–25: Postgraduate course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago.

Apr. 16–19: Postgraduate course in Trauma, Chicago Committee on Trauma of the American College of Surgeons, John B. Murphy Memorial Auditorium, Chicago, Ill.

April 20–25: 50th Annual Session, American College of Physicians, Conrad Hilton Hotel, Chicago, Ill.

Apr. 20–26: First International Symposium on Obstetrics and Gynecology, International College of Surgeons in cooperation with five Chicago medical schools and hospitals. Chicago, Ill.

Apr. 21–23: Tri-State Hospital Assembly—"United for Health Care," Palmer House, Chicago, Ill.

Apr. 21–25: 50th annual session, American College of Physicians, Chicago, Ill.

Apr. 22–25: Four-day Course on Emergency Care and Transportation, Hennepin County General Hospital in cooperation with the American College of Surgeons, Normandy Hotel, Minneapolis, Minn.

Apr. 24–26: 31st Annual Session, American Academy of Physical Medicine and Rehabilitation, Sheraton–Chicago Hotel, Chicago.

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

June 10–13: Annual convention, Catholic Hospital Association, Minneapolis, Minn.

Sept. 15–16: Biennial meeting of State Medical Journal Advertising Bureau, Chicago, Ill.

Oct. 25–26: North Central Medical Conference, St. Paul Hilton, St. Paul, Minn.

Nov. 30–Dec. 5: Radiological Society of North America, Chicago, Ill.

1969 OTHERS

Apr.: AHA Council on Clinical Cardiology—"Clinical Electrocardiography and Vectorcardiography," Augusta Ga.

Apr. 9–11: Management and Care of Respiratory Insufficiency, University of Colorado School of Medicine, Denver, Colo.

Apr. 18: Annual symposium on Infectious Diseases, American Academy of General Practice, Battenfield Auditorium, Kansas City, Kan.

Apr. 21–23: Annual spring session, American Academy of Pediatrics, Sheraton–Boston Hotel, Boston, Mass.

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

Apr. 28–May 1: Annual Clinical Meeting, American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Fla.

May 8–10: National Conference on Breast Cancer, American Cancer Society, Shoreham Hotel, Washington, D.C.

May 12–16: ACP postgraduate course—Internal Medicine, University of Pennsylvania School of Medicine (Pennsylvania Hospital), Philadelphia, Pa.

May 18–21: Annual Meeting, Pharmaceutical Manufacturers Association, The Greenbrier, White Sulphur Springs, W. Va.

June: AHA Council on Clinical Cardiology, title and location to be announced.

June 9–13: ACP postgraduate course—Neurology for the Internist, Bowman Gray School of Medicine, Winston-Salem, N.C.

June 16–19: ACP postgraduate course—Auscultation of the Heart, University of Oregon Medical School, Portland, Ore.

June 16–20: ACP postgraduate course—Hematology, University of Rochester School of Medicine, Rochester, N.Y.

July 7–11: Postgraduate Course—Clinical Electrocardiographic Interpretation, Hahnemann Medical College and Hospital, Philadelphia, Pa.

MEDICAL MEETINGS *continued*

July 14–18: Postgraduate course—Interpretation of Cardiac Arrhythmias, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 11–15: American Bar Association, Dallas, Tex.

Aug. 11–17: Postgraduate course—Space Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 28–Oct. 3: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology—"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 7–11: Western Conference of Prepaid Plans, Sun Valley, Idaho.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Nov. 20: Annual Membership Meeting, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psycosomatic Seminars), to South Pacific.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1969 AMA

July 13–19: Annual meeting, American Medical Association, New York City.

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

May 11–14: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1970 OTHERS

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

1971 OTHERS

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

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REFERENCES:

1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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Jackson Clinic and Foundation

The Spring Postgraduate Meeting of the Jackson Clinic and Foundation will be held Thursday, May 1, at the Park Motor Inn, Madison. Registration starts at 1:30 p.m. and the scientific program at 2 p.m.

The guest speaker will be Dr. Joseph M. Kiely of the department of internal medicine at the Mayo Clinic, who will speak on "Current Use of Computers in Clinical Medicine." Doctor Kiely will also participate in an oncology panel discussion on "The Treatment of the Five Most Common Tumors."

Jackson Clinic speakers will be Drs. Laszlo Kaveggia, department of urology; David G. Bryant, department of orthopedics; Barbara A. Brew, department of obstetrics and gynecology; and Carl G. Silverman and Blake E. Waterhouse, department of internal medicine.

Wives of visiting physicians may attend the social hour and dinner which follow the scientific program at 5:30 p.m. There is no charge for the scientific program or for the social hour and dinner. All interested physicians are invited.

Emergency Care and Transportation Course

The Hennepin County General Hospital, in cooperation with the Minnesota Committee on Trauma of the American College of Surgeons, is sponsoring its ninth four-day course on Emergency Care and Transportation Apr. 22 through 25 at the Normandy Hotel, 4th Avenue at 8th Street, Minneapolis, Minn.

Purpose of the course is to adequately train emergency personnel in victim care beyond Advanced First Aid. All medical subjects are taught by physicians who are experts in their field of medicine.

The course is generally attended by nurses, ambulance drivers, police officers, firemen, and civil defense personnel from Minnesota, North Dakota, South Dakota, Iowa, and Wisconsin.

Registration fee: $35 (includes 4 lunches, coffee breaks, and evening meal on Apr. 24). Class limited to 150.

For further information write to: Emergency Care & Transportation Course, American College of Surgeons, Minnesota Committee on Trauma, % Hennepin County General Hospital, 5th and Portland, Minneapolis, Minn. 55415.

American Academy of Pediatrics

Youth in revolt, critical congenital heart disease in newborn infants, the short child, changing patterns of pediatric care, and pediatric emergencies, will be among the many informative and provocative subjects to be discussed during the American Academy of Pediatrics' annual spring session, April 21–23, in Boston, Mass., in the Sheraton–Boston Hotel.

The meeting will feature closed-circuit color television clinical presentations, a diversified scientific program, and more than 90 scientific and technical exhibits.

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One panel discussion, entitled, "pediatric pot-pourri," will include presentations on tetanus immunizations, mumps immunization, and comparison of immunity status of children in the inner city and in the suburbs.

Other special activities will include a panel discussion sponsored by the Academy Head Start Medical Consultation Service entitled, "Problems of a Head Start Consultant," and a special luncheon meeting of the Academy's Council on Pediatric Practice, on Monday, April 21.

AMA's 1969 Annual Convention

New York City is the site of the American Medical Association's 118th Annual Convention, July 13 through 17.

The nation's largest city has been host to two AMA annual conventions in this decade—in 1961 and 1965—and attendance at each exceeded 60,000.

A total registration of 60,000 is predicted for the 1969 convention, including some 22,500 physicians. Medical students, nurses and other members of allied medical professions, industrial exhibitors, and guests make up the rest of the registrants.

Four general scientific sessions are planned:

* Human Sexuality
* Physical Fitness and Aging
* Impact of Medical Education on Patient Care
* Chronic Pulmonary Insufficiency and Air Pollution Problems

Each of 22 scientific sections also will present a program. The 23rd section—on special topics—plans six sessions:

* Drug Utilization (in cooperation with AMA's Council on Drugs)
* Mental Health Dynamics in the Pre-School Child (in cooperation with AMA's Council on Mental Health)
* Disaster Planning for Aviation Accidents (in cooperation with AMA's Committee on Disaster Medical Care)
* Neurological Surgery
* Nuclear Medicine
* Plastic and Maxillofacial Surgery

The May 26 issue of The Journal of the American Medical Association will list the entire scientific program.

Society for Cryosurgery

All cryosurgeons and others interested in low-temperature therapy who are attending the 1969 A.M.A. Annual Convention in New York City are invited to a social hour Tuesday, July 15, 5:00 P.M. to 7:00 P.M. Secure admission ticket and information on location of party from the attendant at the desk assigned to the SOCIETY FOR CRYOSURGERY in the general registration area in the Coliseum. Society members free; nominal charge for guests.

Tour of Vienna's Medical Highlights

A new afternoon sightseeing tour, which visits many of Vienna's medical highlights, will be of interest both to physicians and to those interested in the history and development of medical science.

The tour visits the hospital quarter, the Museum of Medical Sciences, and the sites connected with Austria's great pioneering physicians: Karl Landsteiner, who discovered blood types; Clemens von Pirquet, who devised

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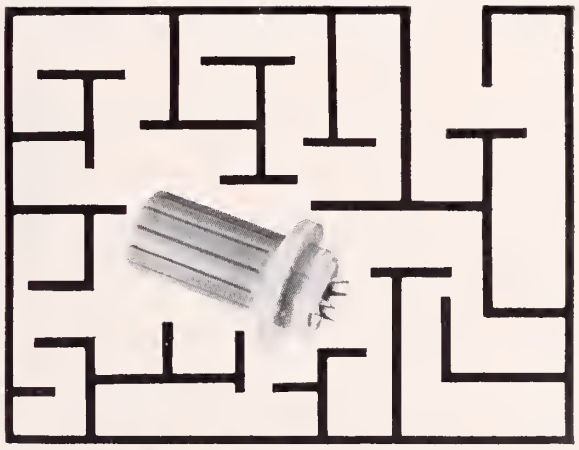

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Her urinary tract infection reveals itself through pain and discomfort.

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Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain Gantanol® (sulfamethoxazole) for the pathogens

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Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

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Vienna's illustrious history in medicine and scientific progress has widespread, general interest.

For more information contact your local travel agent and ask for the "Vienna Medical Tour" as published in the Austrian Travel Planning Kit, 1969, or AUSTRIAN NATIONAL TOURIST OFFICE, 444 Madison Avenue, New York, New York 10022.

Course in Trauma, Chicago

The Chicago Committee on Trauma of the American College of Surgeons is presenting its 13th annual postgraduate course in Trauma Apr. 16–19 at John B. Murphy Memorial Auditorium, Chicago.

Program is acceptable for 26 elective hours by the American Academy of General Practice.

Registration fee: $90 (residents and interns admitted free with letter of authorization). Advance registration to: James P. Ahstrom, Jr., MD, Chairman, Thirteenth Postgraduate Course, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611.

Obstetrician–Gynecologists to Meet

The 17th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists will be held at the Americana Hotel in Bal Harbour, Fla., Apr. 28 to May 1. Twelve postgraduate courses will be conducted immediately prior to the meeting on Apr. 26 and 27.

Both the clinical meeting and the postgraduate courses are open to all physicians regardless of specialty and the College invites them to attend. Registration fee for physicians who are not members of the College is $50 for the clinical meeting and $45 for the postgraduate courses.

During the meeting virtually every major obstetric–gynecologic topic will receive attention via formal papers, colloquia, panel discussions, correlated seminars, luncheon and breakfast conferences, and reports on current investigations. In addition there will be a showing of new motion pictures pertaining to the specialty as well as 250 scientific and industrial exhibits.

Some 500 nationally eminent physicians, most of whom are fellows of the College, will present the program. Approximately 3,000 physicians are expected to attend the meeting.

For complete information about the meeting and/or postgraduate courses, physicians should contact the Meeting Services Department of the College, 79 West Monroe, Chicago, Ill. 60603.

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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. **Indications:** Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

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"To preserve and improve the health of the people"

A "GREEN PAPER"

of the
State Medical Society of Wisconsin

to the Governor, the Legislature
and the people
of the
State of Wisconsin

MEMBERS OF THE COUNCIL (Board of Directors) of the State Medical Society of Wisconsin, seated around the Council table are, starting at left: Drs. E. P. Rohde, Galesville; G. A. Behnke, Kaukauna; S. W. Hollenbeck, Milwaukee; W. J. Houghton, Milwaukee; W. R. Manz, Eau Claire; J. M. Sullivan, Milwaukee; J. E. Dettmann, Green Bay; W. J. Egan, Milwaukee; R. E. Callan, Milwaukee; H. G. Bayley, Beaver Dam; C. W. Stoops, Madison; W. D. James, Oconomowoc; E. J. Nordby, Madison, and Mr. Wilbur J. Schmidt, Madison, secretary of the State Department of Health and Social Services, a guest. Partially hidden are Mr. Frank Newgent, Madison, administrator of the State Division of Family Services, a guest; Drs. L. J. Van Hecke, Milwaukee, and E. P. Ludwig, Wausau. Continuing in view are Drs. H. W. Carey, Lancaster; J. W. Boren, Marinette; Marvin Wright, Rhinelander; J. W. McRoberts, Sheboygan; S. L. Chojnacki, Milwaukee; and, in front, Dr. H. J. Kief, Fond du Lac.

In the background, clockwise, are: H. O. Brower, director, Section Services of the Society; Dr. R. E. Galasinski, Milwaukee, delegate to the AMA; John A. Kluwin and Robert B. L. Murphy, consulting attorneys. Staff members: H. B. Maroney, assistant secretary; J. C. LaBissoniere, director, Regional Services; E. R. Thayer, director, Socio–Economic Medicine; at right, standing: C. H. Crownhart, secretary and general manager; and Miss Joan Pyre, committee secretary.

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"To preserve and improve the health of the people"

These few words express the goal which the State Medical Society of Wisconsin sees as its prime responsibility. This much the public expects. Nothing less can we do. We therefore present this "Green Paper" to express our interest in the achievement of the best possible health care for all the people of Wisconsin. We present it in green because this color by tradition is representative of health and the medical profession. It is out of a tradition of concern for human health and welfare—and a special understanding of health care that has come with years of training and experience—that we submit a number of guidelines for health care in this state.

A PERSPECTIVE

In 1841, seven years before Wisconsin became a state, the State Medical Society of Wisconsin was created by an act of the Territorial Legislature.

The early years of the Society were devoted to drafting laws for elevating the standards of medical practice in the state, legalizing the study of anatomical science, and developing basic medical education. Over the years, many important medical and health milestones have been established through the efforts of the State Medical Society or with its support.

As long ago as 1856, the Society urged the construction of facilities for the mentally ill. Before the turn of the century, the society led a bold but successful fight against blindness in infants and the ravages of tuberculosis in our State. Through the Society's determined efforts, an endowment of $1 million was created in 1919 for Marquette University School of Medicine.

More recent years have seen a flood of new drugs, new treatment and new knowledge and many dramatic advances such as the conquering of polio and the transplant of the human heart. With these advances have come new ideas for financing health care, new government programs, and new, but not surprising, demands by the public for services.

The State Medical Society of Wisconsin, through its 54 county or multi-county societies, and its more than 4,000 members, works to improve medical science and practice and to expand the availability of the highest quality of health care for all. These efforts, combined with those in related health fields, the universities, government, industry, labor and the public itself, have brought Wisconsin a state of good health envied by many.

Yet the goal is always ahead. And we continue to seek it.

A PRINCIPLE

Physicians, as do most individuals in today's society, express varying opinions on many subjects, including those medical. This opportunity to think and act in an atmosphere of freedom is an opportunity jealously guarded by the medical profession, as by many others.

Nowhere is this outlook more vividly expressed than in a statement of the State Medical Society entered in the Congressional Record–Senate, page 6559, March 29, 1966:

> "Medicare has now become the law of the land through the democratic processes of our country, processes of which we may all be proud.
>
> "During debates upon the measure, the medical profession voiced its opposition, its reasons for that opposition, and presented alternative proposals. That is a fundamental privilege of the democratic process, a privilege which all citizens must cherish and protect.
>
> "But now that medicare is law, the State Medical Society of Wisconsin, through its members, will provide full measure of constructive leadership in its administration. Where we find improvement necessary, we will speak up. Where deficiencies become obvious, we will not hestitate to point them out. And where the law is effective, we will express our opinion on that as well.
>
> "Since this law is now a fact, it will require the kind of leadership that the medical profession, and only the medical profession, can provide. We will provide it.
>
> "Nothing less than that could we do in good faith to our patients and in satisfaction of our professional and civic conscience."

Nothing less than this can we do in *all* matters of health care.

We will endeavor to provide leadership, present views and work for what we believe is best. We will emphasize medicine as a service, not a commodity; and its availability to mankind regardless of race, color or economic status will have primary attention. We have faith that the strength of free enterprise in medicine, as in other walks of life, will be measured by its accomplishments in the public interest.

THE FOLLOWING PAGES outline policy positions and established goals of the State Medical Society of Wisconsin to meet the needs of our citizens in health care in the years to come. We invite your participation with us in achieving the highest possible level of health care for all.

State Medical Society of Wisconsin
March, 1969

Demand for Physicians Services

A growing disproportion between the numbers of physicians and patients in Wisconsin combined with a rapidly rising demand of the public for more health services has created a call for action to provide more physicians for our state.

Wisconsin has 112 patient-care physicians per 100,000 population as of December 31, 1967. The U. S. rate as a whole is 132. Some of our neighbor states are better off (Minnesota—136; Illinois—125; and Michigan—131), but some are worse off (Indiana—94 and Iowa—105). The number of graduates from Wisconsin medical schools who remain in the state is declining.

The Governor's Task Force on Medical Education has made urgent and important recommendations for remedying the need. Its proposals should have the earliest possible implementation.

Primary is the rapid expansion of the University of Wisconsin Medical School to permit an entering-class capacity of 160 students or more.

Of equal and immediate importance is the preservation of Marquette School of Medicine and its similarly rapid expansion to permit admission of 160 or more students each year. This of necessity means substantial financial assistance from the State of Wisconsin. It must be forthcoming. The people of Wisconsin cannot afford the loss of a medical school.

The State Medical Society believes that the immediate expansion of both schools is the quickest, most economical and most effective way to secure more physicians for Wisconsin.

Society Officers: Drs. W. D. James, president; R. E. Callan, president-elect; and H. J. Kief, past president

Third, planning must begin at once for the establishment of a third medical school. At least 10 years lead time is required, and delay now simply contributes to continued shortage.

The goal is to assure that *every* person interested in and qualified for the study of medicine may have this opportunity.

The State Medical Society of Wisconsin, on December 14, 1968, held a "Conference on Proposals to Ease the Shortage of Physicians in Wisconsin." More than 50 suggestions evolved from this meeting of legislators, physicians, educators and interested citizens. The Society has created a special committee to evaluate these ideas and press for the implementation of those which appear to hold promise.

Among those ideas suggested for legislative consideration are expansion of the two medical schools to 300 freshman places each and to produce more paramedical personnel; expanded loans and scholarships, especially for those from disadvantaged circumstances; tax incentives or direct financial support in return for part-time public health services from physicians who agree to locate in certain rural areas as recommended to the Legislature by the State Medical Society as early as 1953; certain licensure changes; educational innovation to produce more well-qualified physicians more rapidly, and consideration of alternatives to the use of so many full time physicians in administrative positions of government.

For its part, the State Medical Society is launching a 6-point campaign to ease the "doctor drain:" (1) a campaign to get Wisconsin physicians and their wives to express to students and others their confidence in Wisconsin as a good place to live and to practice medicine; (2) distribution of literature appraising Wisconsin's assets as a desirable location for practice; (3) a campagin to convince students in Wisconsin's two medical schools to remain here after obtaining their degrees; (4) expansion of the two medical schools; (5) intensification of the Society's health careers recruitment efforts, and (6) expanded support for medical student loans through contributions to the Society's Charitable, Educational and Scientific Foundation

which already aids 144 students with more than $176,000 in low-interest loans.

Achievement of these goals, especially the expansion of schools, will require a marked increase in support of medical education by the provision of funds through government coupled with support and understanding from industry, foundations, and private individuals.

Specially Trained Groups Ancillary to Medicine

The critical need for increased numbers of well-trained and qualified ancillary health personnel in all categories is recognized by the State Medical Society. The people demand more health services, and to achieve the most efficiency as well as quality, it is becoming increasingly important that the physician delegate some of his tasks to other members of the health care team.

The State Medical Society calls upon public and private health organizations as well as the general public to assist in the recruitment, training and employment of increasing numbers of men and women to fill the opportunities for ancillary health personnel.

Voluntary certification of ancillary groups is believed by the State Medical Society to be the most advisable process for recognizing the development of these valued medical care assistants. The Society's position is clarified in the following statement of policy:

"The tremendous development of medical sciences over the course of the last several decades in particular has brought about almost an explosive growth in the number of fields of special training ancillary to medicine. At the present time there are in the neighborhood of fifty categories of medical technicians. (See appended listing from a September 1959 survey prepared by the Law Division of the American Medical Association for the Committee to Study the Relationship of of Medicine with Allied Health Professions and Services.)

"In Wisconsin there are licenses or certificates permitting limited practice in such varied fields as chiropody, physical therapy, professional nursing, and trained practical nursing.

"The question is presented from time to time, and exists at the present time, whether licensure or certification by the state is the most advisable process for establishing standards of education, examining credentials and abilities, and regulating the practice of such specially trained groups.

Scientific, Professional and Technical Personnel in the Health Fields*

1. Anatomists
2. Audiologists
3. Basal metabolic technicians
4. Bioanalysts
5. Biochemists
6. Biophysicists
7. Biostatisticians
8. Chiropodists
9. Clinical Chemists
10. Corrective therapists
11. Cyto-technologists
12. Dietitians
13. Electrocardiographic technicians
14. Electroencephalographic technicians
15. Electrologists
16. Epidemiologists
17. Histologic technicians
18. Hospital administrators
19. Industrial hygienists
20. Inhalation therapy technicians (oxygen therapy technicians)
21. Lay psychoanalysts
22. Masseurs and Mechano-therapists
23. Medical illustrators
24. Medical record librarians
    Medical record technicians
25. Medical social workers
26. Medical technologists
27. Microbiologists
    Bacteriologists
    Immuno-serologists
    Mycologists
    Parasitologists
    Virologists
28. Midwives
29. Music therapists
30. Nutritionists
31. Occupational therapists
32. Opticians
33. Optometrists
34. Orthoptic technicians
35. Pharmacists
36. Pharmacologists
37. Physical therapists
38. Physiologists
39. Prosthetists
40. Psychiatric social workers
41. Psychologists
    Clinical psychologists
    Counseling and guidance psychologists
42. Public health educators
43. Radiation therapy technicians
44. Recreational therapists
45. Rehabilitation therapists
46. Sanitary engineers
47. Sanitary inspectors
48. Speech therapists (speech pathologists)
49. Vocational counselors
50. X-ray technicians

* A representative but not inclusive tabulation of persons, other than physicians, other than licensed practitioners of the healing arts, dentists, and nurses, who are engaged in investigation, treatment, and prevention of disease and disability, and in promotion of health by virtue of some special skill. There are now more than 300 different skills being trained and utilized in the health care field.

Dr. L. O. Simenstad of Osceola, trustee of the Board of Directors of the AMA; Drs. R. E. Galasinski of Milwaukee and J. M. Bell of Marinette, Wisconsin delegates to the AMA.

"The State Medical Society opposes the further extension of licensure, certification, or registration under Wisconsin law.

"Its reasons for doing so are:

"(1) A limited license seems to stimulate continuing efforts to expand the area of permitted practice without a corresponding expansion of training and qualifications.

"(2) Delegation to one holding a license or registration by the state may be argued as delegation of responsibility within the capacity of that individual to practice, where in fact, the responsibility of a physician and surgeon should be a matter of individual judgment on his part.

"(3) Licensure implies to the public skilled training and a right of freedom of practice within those skills, without necessarily defining the precise area of practice.

"These are among the more basic reasons. Others could be enumerated.

"The State Medical Society feels that the present program of voluntary certification, adaptable to the needs of the time, to the growth of the science, and particularly framed in light of practical considerations, will assure the public of a greater supply of these essential and valued assistants.

"However, the State Medical Society can at the best but express its views. Under some circumstances it might actively oppose state certification or licensing. It cannot do other than bring its influence to bear, and that may at times be insufficient or, indeed, the circumstances may arise where the Society would support such legislation.

"In any event, the Society believes that whatever legislation might conceivably be enacted in the future, these matters should be kept well in mind:

"(1) The group to be certified or licensed by the state should pay a sufficient amount for initial licensing and for annual registration as will assure the maintenance of proper records and the payment of a salary sufficient as to command administrative attention.

"(2) Any such legislation should have adequate provision for enforcement and should broadly outline proposals therefor.

"(3) Since such certification or licensure is ancillary to the field of medical practice, it would be proper and preferable that the board or committee be under the broad supervision of the State Board of Medical Examiners.

"(4) The fact of proposed enactment of such legislation should be widely known throughout the state so that persons to be affected by it may have ample opportunity to understand it and its application to them."

Further, whenever a group is licensed by the state to treat the sick, its members should be required to pass basic science examinations and be subjected to the same standards of practice and care as are imposed upon physicians.

Medical Education

We commend to your attention the records and progress of the University of Wisconsin Medical School and Marquette School of Medicine. Dean Peter Eichman, Madison, and Dean Gerald Kerrigan, Milwaukee, and their respective staffs are engaged in continuing and major review of their medical school curricula in the hope of training more physicians, more rapidly, and better equipped than in the past to meet the needs of the patient. Among the changes illustrating the significance of these efforts is one at the University of Wisconsin Medical School to emphasize the training of "family care" physicians. This is one of medicine's answers to the public desire for family doctors.

This, and similar efforts of both schools, deserve the fullest support of the Governor, his administrators and the Legislature.

At the same time, the State Medical Society and the two medical schools are deeply and cooperatively engaged in active extension of medical knowledge from the research level directly to the practitioner through the Wisconsin Regional Medical Program. While this program is primarily funded by the federal government, its activities may have a significant effect upon quality of health care and the rapidity with which new medical techniques may be made generally available to the public.

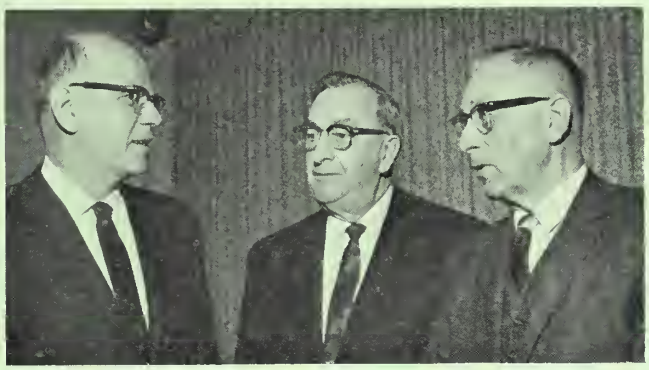
Protection of the Health of the Public

Cultism and quackery have no place in sound health care. Patients should entrust their health care only to those who have a broad scientific knowledge of diseases and ailments of all kinds, and who are capable of diagnosing and treating them with all the resources of modern medicine. The delay of proper medical care caused by cultists and quacks and their opposition to the many scientific advances in modern medicine, such as life saving vaccines, often ends with tragic results.

Unfortunately, the Legislature is sometimes used by such groups to achieve by law what they cannot accomplish through education and public acceptance of demonstrable training and scientific skill.

Recently, chiropractic in Wisconsin has sought to expand its legislative authority in the area of diagnosis and treatment. In light of these efforts, the State Medical Society feels impelled to invite the attention of the State Legislature to a most significant "in depth" study and report made at the request of the United States Congress and presented to it on December 28, 1968 by the Department of Health, Education and Welfare. The full report is available upon request, but the following "Conclusions" and "Recommendations" are of primary importance:

Councilor: Dr. C. W. Stoops; Speaker of the Society's House of Delegates: Dr. G. A. Behnke; and Councilor: Dr. W. J. Egan



Councilors: Drs. Marvin Wright, W. R. Manz, and E. P. Ludwig

"Conclusions"

"1. There is a body of basic scientific knowledge related to health, disease, and health care. Chiropractic practitioners ignore or take exception to much of this knowledge despite the fact that they have not undertaken adequate scientific research.

"2. There is no valid evidence that subluxation, if it exists, is a significant factor in disease processes. Therefore, the broad application to health care of a diagnostic procedure such as spinal analysis and a treatment procedure such as spinal adjustment is not justified.

"3. The inadequacies of chiropractic education, coupled with a theory that de-emphasizes proven causative factors in disease processes, proven methods of treatment, and differential diagnosis, make it unlikely that a chiropractor can make an adequate diagnosis and know the appropriate treatment, and subsequently provide the indicated treatment or refer the patient. Lack of these capabilities in independent practitioners is undesirable because: appropriate treatment could be delayed or prevented entirely; appropriate treatment might be interrupted or stopped completely; the treatment offered could be contraindicated; all treatments have some risk involved with their administration, and inappropriate treatment exposes the patient to this risk unnecessarily.

"4. Manipulation (including chiropractic manipulation) may be a valuable technique for relief of pain due to loss of mobility of joints. Research in this area is inadequate; therefore, it is suggested that research that is based upon the scientific method be undertaken with respect to manipulation.

"Recommendation"

"Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the Medicare program."

The implication is clear and unequivocal: There is very serious doubt as to the wisdom of having granted to chiropractic any type of licensing for the diagnosis or treatment of the sick. At the very least, the protection of the public health demands an immediate halt to any further extension of privilege or practice to this group.

Health Care Costs

Unusual publicity has been directed to the rising costs of health care in an economy which, itself, is characterized by unusual expansion in every respect.

Only a small percentage of the health care dollar is related to physician's fees. Nonetheless, the physician cannot detach himself from his patient's problem in financing his health care costs. The State Medical Society of Wisconsin advises every member to be mindful of the economic consequences of the treatment he prescribes.

It must be made clear, however, that the total problem of health care costs is a many faceted one. Among other things, rising health care costs are the result of scientific and technical advances in care, increased use of health services by all people, the patient's demand and the profession's goal to provide even higher quality care for better health results, high demand for services from providers in short supply, and general inflationary cost trends of all types.

The State Medical Society believes that the public can readily accept increasing cost brought on by scientific advance and higher quality of care. But the public protests, and the medical profession joins in protesting, rising costs because of inflation and manpower shortage.

As to the latter, the State Medical Society has proposed both governmental and community effort at solutions in which it will be an active partner. As for inflation, the medical profession would call upon all elements of society to seek a halt to the inflationary spiral and to achieve the most efficient and productive use of the personal and tax dollars spent for health care.

Councilors: Drs. L. J. Van Hecke and E. J. Nordby, Council chairman

The State Medical Society's interest in this area is exemplified by the following letter sent by its President on January 3, 1969, to Governor Warren P. Knowles upon release of news about an impending state deficit:

"Dear Governor:

"The State Medical Society of Wisconsin shares your concern with rising public welfare expenditures, especially as these involve health care. This is consistent with our training and responsibility in the totality of health care for the individual.

"To this end, our Society, last November 16, hosted a statewide conference on health care costs. It was attended by nearly 50 representatives of state government agencies, health care providers and the business, labor and 'consumer' community. In light of your action, I am asking that this conference be reconvened promptly so that the full knowledge and energies of this group can be directed toward any immediate remedies available to Wisconsin.

"Further, I understand that Title XIX (Medicaid) expenditures in Wisconsin totaled $115,000,000 for the fiscal year ending June 30, 1968. As citizens and taxpayers, physicians are interested in so large an expenditure, although I note that only about $9 million of this went for physicians' services. This is less than eight cents of each Medicaid dollar.

"Nonetheless, let me assure you, the members of the Wisconsin Legislature and appropriate department heads, that the State Medical Society stands ready to offer every cooperation and assistance in reviewing Wisconsin's health care program under public welfare. We must seek the utmost economy while, at the same time, assuring needed and quality health care for all, including the less fortunate in our midst.

"Sincerely,

W. D. James, M.D.
President"

The State Medical Society has convened two meetings of those most directly concerned with the provision of health services in Wisconsin. It will continue to work cooperatively with all—government, public and the professions—to find solutions that will meet today's needs and tomorrow's goals.

The Council of the State Medical Society has reviewed the general performance of its members during the past two and one-half years under major tax-supported health programs, including Title XIX benefits under the Medical Assistance Payments Act in this state.

The practicing physicians of this state are to be commended for keeping charges for professional services to patients under Medicaid within reasonable limits. The Society is confident that the profession will

continue its noteworthy performance in the area of economic medicine.

The Society has asked the profession to continue to make careful determination of what type of institutional care is needed, and the limits of its medically warranted duration, where home care is not a feasible alternative for the patient. To that end, the Society urges the importance of having each physician establish, and continually review, treatment and other professional decisions to assure that they are realistic, and that they will result in the best use of public monies consistent with sound patient care.

The physician, in the course of treating those who are beneficiaries of government health programs, must himself distinguish and must emphasize to patients, families and administrators, the marked difference between rehabilitation programs and custodial care, and the reasons both or only one may be indicated in a particular situation.

Continued performance in this fashion will best assure the discharge of the physician's dual role of an always concerned professional and a responsible citizen.

The Society is convinced that adequate health insurance coverage is the best mechanism for the financing of quality health care. Its own health insurance division, Wisconsin Blue Shield (WPS) has become identified nationwide as a pioneer in protection against major illness costs, over-age-65 coverage, drug, dental and related benefits, and the development of the "customary, usual and reasonable" concept of payment for medical services. The latter has proven itself so adaptable to actuarial rating that it has spread across the country in use by almost every "Blue" plan, many commercial carriers, and acceptance in government programs such as Medicare and Medicaid.

Corollary to this concept of "customary, usual and reasonable" is the guarantee of the State Medical Society of Wisconsin that when a dispute over physician fees arises, the judgment of the Society, after appropriate review of the circumstances, shall be binding upon all parties, including the physician.

In this context, medicine is providing a public service of inestimable value which has no counterpart short of involved and possibly expensive court action.

Legislative Assistance in Health

The dramatic progress of medicine, especially in the last quarter century, has produced startling advances in drugs, research and the application of sophisticated diagnostic and therapeutic devices to the practice of medicine. As the art and science of medicine changes, so, too, must the legal and socio–economic framework change within which medicine is practiced. With increasing frequency, the legislature is faced with decisions involving analysis of complex medical and scientific fields.

The State Medical Society of Wisconsin recommends that the legislature take two steps to assist itself in this area:

1. Create a special committee to review proposed bills on mandatory medical tests and procedures. Such a committee would be of great assistance in solving problems such as those involved in PKU testing, the use of silver nitrate for the prevention of blindness and plans for measles immunization and other disease controls utilizing vaccines.
2. Creation of a state administrative body to evaluate public health proposals dealing with scientific matters pending before various branches of the state government. It would be designed to avoid political decisions on purely scientific matters. The Society suggests that the body be identified as a "Council on Science" and that it be composed of the chairmen of the Senate and Assembly Committees on Public Welfare, the State Health Officer, the secretary of the State Board of Medical Examiners and the deans of the University of Wisconsin and Marquette Medical Schools.

The complexity of modern medical science clearly indicates the necessity for specialized assistance to the legislature in permitting it to more adequately evaluate the rapid changes in medicine and the allied sciences.

Environmental Health

Every community has pollution problems and they affect everyone in the State of Wisconsin—through air, soil, water, food, noise, the total environment—and through the pocketbooks of every citizen. Citizens, with stinging eyes and hacking coughs, look to the medical profession for relief of environmental pollution. The menace is to health as much as it is to economic well-being.

Since 1876, the State Medical Society has urged the state and municipalities to preserve water supplies against unnecessary and avoidable contamination. In recognition of the growing seriousness of the problem, the Society recently appointed a Commission on Health and Natural Resources to explore the growing health hazards of water and air pollution, contamination of swimming areas, and to work with other agencies, public and private, concerned with health problems arising out of use of the state's natural resources.

THE COMMISSION ON PUBLIC POLICY of the State Medical Society of Wisconsin, which reviews state legislative proposals affecting health care, is shown above at a recent meeting. Seated around the table, left to right, are: Drs. E. J. Zeiss, Appleton; K. L. Siebecker, Madison; J. M. Lubitz, Brookfield; Wayne Boulanger, Milwaukee; J. F. Morrissey, Madison; T. W. Tormey, Jr., Madison, a guest (secretary of the State Medical Examining Board); L. J. Kurten, Racine; T. E. Henney, Portage; W. T. Russell, Sun Prairie, chairman; Mr. H. B. Maroney, Madison, Society assistant secretary; Drs. W. D. James, Oconomowoc, Society president; C. F. Broderick, Wisconsin Dells, vice-chairman (hidden); E. C. Quackenbush, Hartford; J. R. Schroder, Janesville; H. A. Peters, Madison; and Mrs. Max M. Smith, Madison, a guest (legislative chairman of the Woman's Auxiliary to the State Medical Society); and standing, left to right, are: Mr. W. P. Horton and Mr. G. W. Crownhart, Madison, consulting attorneys; Mr. C. H. Crownhart, Madison, secretary and general manager of the State Medical Society; Mr. R. B. L. Murphy, Madison, consulting attorney; Mr. Elmer Sandeen and Mr. Glenn Waldschmidt of Rothschild, and Mr. Eric Jacobson, Appleton, Society regional representatives; Mr. Robert Heider, Milwaukee, consulting attorney; and Mr. Earl R. Thayer, Madison, director of Socio–Economic Medicine of the State Medical Society. Commission members not present at the meeting are: Drs. L. W. Schrank, Waupun; P. A. Sciarra, Sheboygan; R. L. Gilbert, La Crosse; J. C. Fralich, Racine; R. C. Wixson, Madison; J. G. Frisch, Milwaukee; J. L. Teresi, Milwaukee; Lyle Edelblute, Green Bay; D. S. Schuster, Madison; N. G. Bauch, Milwaukee; J. A. Van Susteren, La Crosse; and R. E. Callan, Milwaukee, Society president-elect.

The State Medical Society compliments the State of Wisconsin in leading the fight against pollution and in its actions to preserve the State's remarkable natural resources. We urge the State to continue and expand these activities—our very best efforts in pollution control are essential to protect life and health.

Occupational Health and Safety

Among the many health related interests of the State Medical Society of Wisconsin is its concern with the special problems of health and safety that surround one's occupation, whether it be at home, rural or industrial. Cooperative government–private leadership in Wisconsin has resulted in dramatic forward strides in improving occupational safety and health programs for all workers in Wisconsin. Medicine had a proud role in the enactment of the first Workmen's Compensation Law in Wisconsin in 1911. There can be no letup in the determination to provide safe and healthful working conditions. Widespread educational programs for health and safety on and off the job must continue undiminished.

The State Medical Society is especially concerned with legislation designed to reduce the great human costs of highway accidents. To this end, it promotes:

(a) in-person driver license renewal measures
(b) mandatory driver education courses in high schools
(c) completion of driver education course prior to licensure for those under 18
(d) special licenses for operation of any two- or three-wheeled motor vehicles
(e) safety helmets for drivers and passengers of two- or three-wheeled motor vehicles
(f) adoption of minimum standards for ambulance operation
(g) adoption of an implied consent law to aid in control and deterrance of the drinking–driving problem
(h) a requirement that all autos sold in Wisconsin meet minimum standards for passenger safety devices as established by the Federal Administrator of General Services
(i) expansion of first aid training for all drivers, particularly those on emergency services
(j) establishment of a medical advisory committee to consider all areas of medical limitation for driver licensing.

In addition, it supports the adoption of a standardized slow-moving vehicle emblem for this State.

Public Health

Public health is a specialty of medicine, particularly related to vital statistics, public health education, environmental sanitation, public health laboratories, and the prevention and control of communicable diseases. This is an essential service having direct significance for everyone in the State.

Wisconsin has been fortunate in years past to have a strong and effective State Board of Health. With the merging of Health and Public Welfare into a single department, it is to be hoped that no less emphasis be given to the important functions of public health in the future.

Although the State Division of Health has been changing and developing with medical and public health progress, Wisconsin's local public health system borders on the ancient and outmoded.

The State Medical Society believes that a major goal for improved public health is the "establishment of full-time, adequately budgeted, city–county, county and multiple-county health departments staffed by professionally qualified personnel."

With the development at the federal level of a program for Comprehensive Health Planning, a new dimension has been added to public health in Wisconsin.

Even though the medical profession has minority representation in the basic structure of Comprehensive Health Planning, it accepts the challenge to continue sound health leadership for the improvement of the health of all Wisconsin's citizens.

Life is short...Art is long...Experience is difficult

ONE OF THE FIRST recorded admonitions of Hippocrates to fellow physicians concerning medicine are the Latin words contained in the emblem symbolic of this Foundation. These words as they appear in their literal translation as above are as true today as they were when first spoken. It is indeed obvious that the need for more and better medicine is becoming more and more paramount as we come to understand the human processes to ever greater degrees. Together with this growth of knowledge must come increased public understanding of it, so that the people it is to benefit will take advantage of its availability. By far the best means of accomplishing this is through the efforts of an educational and scientific foundation specifically formed for these purposes.

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION

OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE CHARACTER of the medical profession shapes not only its own destiny but has profound influence on the health and well-being of all the people. This character finds its roots in the age-old belief that individual freedom and well-being hinge on people helping themselves and one another. For 128 years, the State Medical Society of Wisconsin has reflected this spirit in its activities and in its services to the people of Wisconsin and to member physicians. ■ The Charitable, Educational and Scientific Foundation, created in 1951, offers a permanent and reliable mechanism for administering and accepting voluntary contributions to further the charitable, educational and scientific programs which are a vital link in the continuation of medical progress in Wisconsin. ■ Physicians, nonmedical persons, business, industry, and other foundations have found the CES Foundation an avenue of common interest and effort. ■ Some projects of the Foundation include loans to medical students, postgraduate teaching programs, scientific research activities, special conferences on maternal mortality, infant care, mental health, medical aspects of sports and aging, collections of medical artifacts and other memorabilia, hobbies for health collections, assistance to colleagues in need, and memorial lectures and donations. ■ A special project of the Foundation is the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien where a series of exhibits and displays explains the progress made in medical science during the past few centuries.

The "Home" of the State Medical Society—on the south shore of Lake Monona in Madison—houses the Wisconsin Medical Journal, the Society's Blue Shield (WPS) insurance plan, general administrative offices and meeting rooms. Nearly 200 committee and other meetings are held here annually.

THE PURPOSES of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE II of the Constitution and Bylaws of the State Medical Society of Wisconsin.

State Medical Society of Wisconsin

330 EAST LAKESIDE STREET • MADISON, WISCONSIN

SERVICES

- CONDUCTS postgraduate medical refresher courses for physicians.
- PUBLISHES the Wisconsin Medical Journal.
- OPERATES Wisconsin Blue Shield (WPS) to provide surgical–medical–hospital insurance for the people of Wisconsin.
- CONTRACTS with the federal government to provide medical–surgical benefits under Medicare in all counties of Wisconsin except Milwaukee. It also contracts with the State of Wisconsin to provide similar benefits under Medicaid.
- OPERATES a Charitable, Educational and Scientific Foundation including the Museum of Medical Progress at Prairie du Chien.
- SPONSORS the "March of Medicine" series on radio and similar health education programs for the public.
- REPRESENTS physician members in legislative matters.
- KEEPS physicians informed of medical–legal–ecomonic matters.
- MAINTAINS a physician placement service.
- SPONSORS an annual Wisconsin Work Week of Health.
- PUBLISHES and distributes to industry the Open Panels of physicians under Workmen's Compensation.
- SPONSORS Health Career Days.
- OFFERS Speakers Service to communities and civic groups.
- OFFERS films on loan to medical and non-medical groups.

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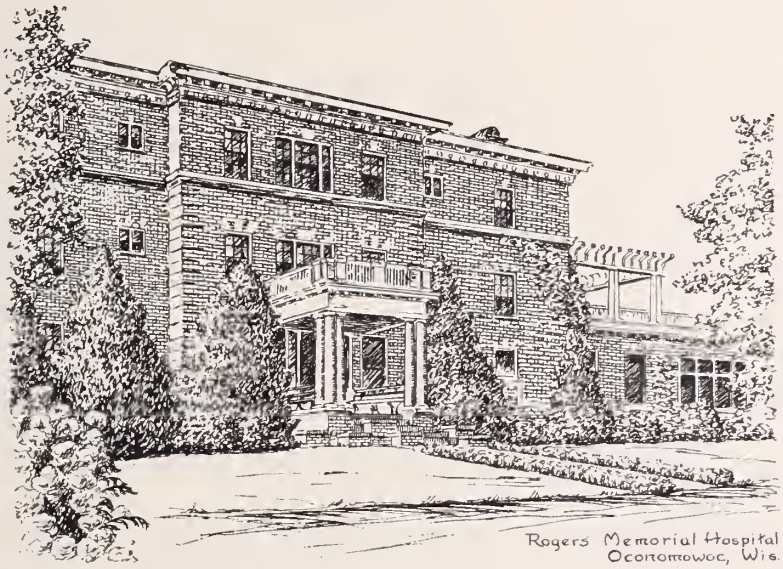

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SECTION OPHTHALMOLOGY

MARCH 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

EXECUTIVE COMMITTEE MEETING

The Executive Committee of the Section met recently at the State Medical Society headquarters in Madison. Attending were Doctors Richard W. Ashley of Kenosha; Ralph Teitgen, Milwaukee; Carl F. Schmidt, La Crosse; William C. Parks, Milwaukee; James V. Bolger, Waukesha; George Anderson, Stevens Point; Elmer E. Johnson, Madison; and James C. Allen, Madison.

Mrs. Edward Neilson, president of the Auxiliary to the Wisconsin Opticianry Society, was a guest. Among items discussed were the following:

ANNUAL MEETING PROGRAM

The all-day program of the Section on Ophthalmology, in conjunction with the State Medical Society annual meeting May 13–15, will be on Thursday, May 15, in the Hotel Sheraton–Schroeder.

Starting at 9:00 in the morning there will be available for study stereophotographic demonstrations, continuing until noon. Concurrently there will be two showings of a one and one-half hour movie from 9:00 to 10:30 and 10:30 to 12:00.

A noon luncheon starting at 12:30 will be followed by the annual business meeting of the Section. There will be no guest speaker for the luncheon.

The afternoon program starts at 2:00 with a lecture by Dr. Alston Callahan, president of The Eye Foundation, Inc. of Birmingham, Ala. His subject is "Recent Advances in Ophthalmic Plastic Surgery." At 3:00, Dr. Harry A. Easom, assistant clinical professor of ophthalmology, Marquette School of Medicine, Milwaukee, will present a "Clinicopathological Conference."

A dinner meeting of the Milwaukee Ophthalmological Society will start at 6:30 at the University Club. All ophthalmologists and interested physicians are welcome. Doctor Callahan will be the guest speaker. Dr. Brian C. McLaughlin, president of the Society, will preside.

BOOK MARKS DISTRIBUTED

The Committee approved distribution of a book mark by the Wisconsin Opticianry Society Auxiliary to Wisconsin school children. The book mark defines ophthalmology, optometry, and opticianry. The Section also plans to distribute the book marks to Wisconsin physicians.

LEGISLATIVE MATTERS

The Section recommends support of legislation establishing certification for opticians under the Medical Examining Board and re-introduction of legislation calling for the use of safety glasses in certain academic courses.

MEMBERSHIP ENCOURAGED

The Section encourages ophthalmologists to become members of the following groups:

WISCONSIN ASSOCIATION FOR THE PREVENTION OF BLINDNESS (affiliate of the National Society for the Prevention of Blindness): 312 East Wisconsin Ave., Milwaukee, Wis. 53202.

AMERICAN ASSOCIATION OF OPHTHALMOLOGY: 1100 17th Street NW, Washington, D.C. 20036.

PROFESSIONAL ASSOCIATION FOR CIVIC EDUCATION (PACE): P.O. Box 68, Waterloo, Wis. 53594.

OPHTHALMIC TECHNICIANS COURSE

Information regarding a home study course for training ophthalmic technicians by the American Association of Ophthalmology is available from that organization whose address appears above.

NATIONAL MEETING IN MILWAUKEE

The Section urges all ophthalmologists and other interested physicians to attend the annual conference of the National Society for the Prevention of Blindness to be held May 14–16 at the Pfister Hotel in Milwaukee.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

Dr. Walter Gager of Milwaukee will lecture at the April 22 meeting of the Milwaukee Ophthalmological Society at the University Club of Milwaukee. Interested physicians are welcome. Social hour starts at 5:30.

Further information is available upon request to: James V. Bolger, Jr., MD, 102 East Main St., Waukesha.

NEWS HIGHLIGHTS

Dr. Towne Honored at Hortonville

Dr. William H. Towne,* Outagamie County's oldest practicing physician, was honored for over 60 years of medical service in the Hortonville–Shiocton area at a Recognition Day dinner, program, and reception Feb. 9 in Hortonville.

Nearly 500 persons honored the doctor at a noon dinner and a much larger throng greeted him in the afternoon during a program and reception. Among those attending were many of the 4,000 babies the doctor has delivered.

W. H. Towne, MD

Featured speakers on the program had the following remarks:

"Dr. Towne made medicine a personal matter with his compassion, understanding, wit and humor. The possibility exists for medicine to become a cold business . . . Dr. Towne's service enriched his own soul."—Dr. Donald Bravick,* chief of staff of Appleton Memorial Hospital.

"An uncommon man, a leader. Dr. Towne was dedicated to his work . . . He had the gift of favorably affecting the lives of almost everyone he came in contact with." —Dr. Edward Mielke,* Appleton.

Dr. John Monsted* of New London was to have been on the program but was unable to attend.

A resolution from the Appleton Memorial Hospital's board of directors, a plaque on behalf of those attending the dinner, and an oil picture of Doctor Towne were presented during the program.

The American Medical Association arranged for a national television news coverage service for the occasion and a film of the event was supplied to all major networks. Commemorative booklets prepared by the Hortonville Junior Woman's Club, which sponsored the Recognition Day, were available.

Doctor Towne began his medical practice in Shiocton in 1908 following graduation from the Physicians and Surgeons College, Milwaukee, in 1907 and a year at the Grand Army Home at King. He moved to Hortonville in 1929.

In 1957 the State Medical Society of Wisconsin honored him for 50 years of practice in medicine. In 1954 the Hortonville Commercial Club honored him on his 25th anniversary in the village. Doctor Towne, who celebrated his 87th birthday last September, is now in his 40th year of practice in Hortonville.

SCHOLARSHIP FUND TO HONOR DR. TOWNE

Establishment of a "Dr. Towne Scholarship" was announced by Mrs. Paul Vance, president of the Hortonville Junior Woman's Club, during ceremonies honoring Dr. William H. Towne Feb. 9 in Hortonville.

All proceeds from the recognition day dinner, sales of a picture-packed booklet recalling the life of Doctor Towne, and gifts will be used to establish a scholarship fund.

The scholarship will be presented to a Hortonville high school senior who is entering studies in medicine.

ANNUAL MEETING PROGRAM

The complete program for the 1969 SMS annual meeting appears in this issue starting at page 7. Program booklets will be mailed to physicians in mid-April.

PHYSICIAN BRIEFS

Dr. J. R. Thompson*

. . . Wautoma, recently attended a meeting of the Mexican Society of Gastroenterologists in Orizaba, state of Veracruz, Mexico. An outstanding program under the supervision of Dr. S. Gutierrez-Vasquez, including both wet and dry clinics on biliary tract disease, was audited.

Dr. M. L. Janssen*

. . . Adams, recently was appointed county coroner of Adams County by Governor Warren P. Knowles.

Dr. W. T. Brodhead*

. . . Madison, was inducted as a fellow of the American Academy of Orthopedic Surgeons at the groups annual meeting held recently in New York City. Doctor Brodhead is associated with the Dean Clinic, Madison.

Dr. George Barry*

. . . Monroe, was a delegate from the Wisconsin Society of Internal Medicine to a regional meeting of the American Society of Internal Medicine held in Tampa, Fla., in late January.

Dr. Donald Johnson

. . . Chicago, former flight surgeon for United Air Lines, recently became the first full-time physician at Wisconsin State University–Stevens Point.

Dr. F. H. Zimmermann

. . . Watertown physician and surgeon for 40 years, recently retired from the practice of medicine. In 1964, Doctor Zimmermann went to Ethiopia for four months to serve as the surgeon in charge of a hospital located near Axum, Ethiopia.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dr. L. M. Rauen*

. . . Kenosha, recently was elected president of the Memorial Hospital medical staff. Others elected were: Drs. R. G. Welsch,* president-elect, Edwin H. Barnes,* secretary–treasurer; and Morris Siegel,* past president, will remain on the executive staff. Dr. Blair Bonell,* Dr. R. G. Burnett* and Dr. Walter C. Ratten* were elected to the executive committee.

Dr. Christopher R. Dix*

. . . Milwaukee plastic surgeon, was the featured speaker for the monthly breakfast meeting of the St. Mary's Christian Mother and Alter society held in Elm Grove. Doctor Dix, the immediate past president of The Medical Society of Milwaukee County, spoke on "The Transplant Dilemma."

Dr. Edgar A. Habeck*

. . . and Dr. Leo M. Peters,* Milwaukee, were co-authors of the article, "Evisceration of Bowel Through the Vagina Following Irradiation for Cervical Carcinoma; Report of First Known Case," which was abstracted in the December issue of *International Surgical Digest* from the August 1968 issue of the *Wisconsin Medical Journal.*

Dr. Gerald Gehl

. . . a psychiatry resident at University Hospitals in Madison, has joined the staff of the Counseling Center of Sauk, Juneau, and Richland counties for one day per week.

Dr. Edgar End*

. . . was recently elected to membership in the Undersea Medical Society which was founded in 1967 in Washington, D.C., to aid the advancement of undersea medicine and its supporting sciences. Doctor End is an assistant clinical professor of environmental medicine at Marquette School of Medicine. In Milwaukee he is regarded as a leading specialist in hyperbaric physiology.

Pilot Program on Drug Use Proposed for Appleton Area

A pilot education program for youths and adults on proper use of drugs has been proposed for the Appleton community where authorities say the situation is "critical."

Dr. Darold Treffert,* superintendent of Winnebago State Hospital, Oshkosh, and chairman of the State Medical Society's Division on Alcoholism and Drug Addiction, has been coordinating efforts toward local participation and direction.

The first step was taken early in February with formation of a 17-member steering committee comprised of a doctor, public relations person, and law enforcement expert, and other community workers to forge a task force for the pilot program.

In outlining the program Doctor Treffert said that it would "saturate" both adults and teenagers in Appleton with information about drugs and drug usage. The program would "educate" teachers, guidance counselors, doctors, lawyers, and others working with young persons.

Youths should be asked to assist in planning formats to provide live, vibrant presentations capable of succeeding, he advised.

He emphasized that understanding the narcotics problem is vital to the program's success.

STATE UROLOGISTS TO MEET APRIL 25–26

The annual meeting of the Wisconsin Urological Society will be Apr. 25–26 at the Holiday Inn–Mid Town, Milwaukee.

Guest speaker will be Dr. Ian Thompson, professor and chairman of urology at the University of Missouri.

Interested physicians are invited. Advance reservations and information may be obtained from John D. Silbar, MD, Secretary of WUS, 536 W. Wisconsin Ave., Milwaukee, Wis. 53202.

Appleton Teenagers Fight Drug Use in Schools

Two high school students in Appleton have organized a "Smarteen" club to help in the fight against drug use in the schools, a situation which Appleton authorities term "critical."

As reported in the *Appleton Post–Crescent*, the Appleton Smarteen club is one of many that have sprung up around the country since a Los Angeles "pilot program" a year ago. The national organization has a central office in Los Angeles. It was started by a retired Los Angeles businessman and gained national attention in a television program starring Jack Webb.

The aim of the club is to "eliminate the use of drugs and narcotics through education, common sense, and social pressure."

Smarteen organizers feel the club can both prevent the further spread of the narcotics use problem and help teenagers using drugs to "kick" what might already be a habit.

Smarteen members take a pledge which reads, in part: "I want to be a Smarteen. Enlist me in the fight against teenage drug addiction. I have the courage and maturity to know that using drugs or narcotics of any kind is dangerous to my health, and future success as an individual. My common sense tells me that using drugs is 'square' and not 'smart.'

"In joining Smarteens, I will not use marijuana, LSD, pep pills, goof balls, heroin, glue, or any kind of illegal drug or narcotic."

The Smarteen club will make posters, hold meetings, and carry out projects in their efforts to help the community combat narcotics use among teenagers.

Dr. Max Fox Honored; UW Preceptor

A Milwaukee physician, Dr. Max J. Fox,* was honored by the University of Wisconsin Medical Alumni Association for his more than 20 years of service as a UW medical school preceptor at the medical alumni's winter meeting at the University Club of Milwaukee Feb. 7.

Drs. Middleton and Fox

Doctor Fox was presented the medical alumni commendation by Dr. William S. Middleton,* Madison, emeritus dean of the UW medical school. At the same time the Max Fox Preceptor Recognition Award was established.

A specialist in internal medicine, Doctor Fox is a diagnostician in communicable diseases. In his over 20 years as a preceptor for the University of Wisconsin Medical School and as a teacher at Marquette, Doctor Fox has worked with over 4,000 medical students.

Doctor Fox is an emeritus associate clinical professor of medicine at Marquette School of Medicine. He was named alumnus of the year of Marquette University in 1959. His son, James, is a 1968 UW Medical School graduate.

Dr. Peter L. Eichman,* dean of the UW Medical School, spoke about the latest medical center developments as part of the program. Also participating was Dr. Marc Hansen,* assistant professor of pediatrics at the UW and program director of its primary medical-care program. He spoke on developments in teaching for primary care and family medicine.

Program chairmen were Dr. Roger Laubenheimer,* Shorewood, and Dr. John Peterson,* Wauwatosa.

On Doctor Max J. Fox,
a legendary figure in Wisconsin medicine,
The Wisconsin Medical Alumni Association confers
its Certificate of Commendation

for his faithful and effective preceptorship of University of Wisconsin Medical Students for over twenty-five years. Able clinician and dedicated, if unorthodox, teacher, he was in the main responsible for their indoctrination in communicable diseases. Over and beyond this important function, undoubtedly his greatest contribution to the generations of Wisconsin students was his inculcation in the civic responsibilities of the true physician. By precept and example, he has responded to the prayer of Maimonides:

"Preserve my strength, that I may be able to restore the strength of the rich and the poor, the good and the bad, the friend and the foe. Let me see in the sufferer the man alone."

Herein conveyed, Doctor Fox, is a small measure of the appreciation and the affection of the host of your Wisconsin students.

In witness whereof it is sealed and signed by the Dean of the Medical School and President of the University of Wisconsin Medical Alumni Association.

/s/ Peter L. Eichman, M.D.
Dean of the Medical School

/s/ Richard Wasserburger, M.D.
President of the University of Wisconsin Medical Alumni Association

February 7, 1969

Dr. Sidney K. Wynn*

. . . Milwaukee plastic surgeon, recently returned from a six-week tour of duty at a Saigon children's hospital in Vietnam. The tour was made under auspices of the Children's Medical Relief International, a private philanthropic organization.

Purpose of the program is to try to train more Vietnamese surgeons so they can take over and solve more of their country's health problems themselves.

Dr. Joseph Rose*

. . . a Lena physician since 1907, who discontinued his practice after sustaining an injury in a fall two years ago, was featured in the Jan. 30 issue of the *Oconto County Reporter*. Recollections of the "horse and buggy days," delivering over 5000 babies, methods of treatment over the years, and the honors bestowed on him were included in the article.

Dr. Howard Mauthe*

. . . of Fond du Lac was among 119 radiologists who were made fellows of the American College of Radiology at the annual meeting of the College in Atlanta, Ga., Feb. 21. Doctor Mauthe graduated from the University of Chicago Medical School in 1943 and currently is on the medical staffs of hospitals in Fond du Lac, Berlin, Chilton, Ripon, and Wautoma. He has been associate clinical professor of radiology at Marquette School of Medicine since 1965.

Dr. Darold Treffert*

. . . superintendent of Winnebago State Hospital, Oshkosh, for the third year opened the course, "Problems in Family Living," offered by the Fox Valley Technical Institute–Neenah.

Consisting of seven sessions featuring Winnebago State Hospital staff members as speakers, "Problems in Family Living" is designed to provide parents with new insights into themselves and their children.

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cum laude

V.P.

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With its pronounced calming action, Valium can relieve psychic tension promptly, attenuating its somatic signs and symptoms. Further, Valium is distinctly useful when somatic and depressive symptomatology (secondary to psychic tension) coexist. And Valium is generally well tolerated; in proper maintenance dosage, it seldom dulls the senses or interferes with functioning.

When psychic tension-related insomnia appears, an *h.s.* dose added to the *t.i.d.* schedule helps promote sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Dr. Adam Beck*

. . . will be honored by having a shelter house, to be erected in the new Wautoma city park, named in his honor. The Waushara doctor, who has spent over a half-century serving the area, was featured in the Jan. 30 issue of the *Wautoma, Waushara Argus.*

Dr. F. B. Bersalona

. . . recently joined the staff of the Marshfield Clinic which now has a membership of 82.

Doctor Bersalon, native of the Philippines, received his medical education at the University of the Philippines, Manila, and interned at the Philippines General Hospital. He did a year's residency at Philippines General and then came to the United States under a rotating internship and studied at Northwestern Hospital, Minneapolis, for a year. After spending four years of residency work at the Mayo Clinic, he returned to the Philippines for private practice before joining the Marshfield Clinic in his specialty of otolaryngology.

Dr. A. R. Curreri*

. . . chairman of the Department of Surgery and director of the Division of Clinical Oncology at the University of Wisconsin Medical Center, spoke before the Wisconsin State Medical Assistants Society's 10th annual educational symposium held in Milwaukee. His topic was "The Who, What, How, Why, and When Aspects of Chemotherapy."

Dr. Leonard J. Ganser*

. . . administrator of the State Division of Mental Hygiene, is one of eight members of the Ad Hoc Committee on Financing Community Mental Health Centers of the National Association for Mental Health (NAMH). The committee is studying the most appropriate and practical patterns for continuing the financing of community mental health centers. The committee will advise the NAMH Board of Directors of its recommendations.

Manitowoc Society Developing CHP

Dr. William Randolph,* president of the Manitowoc County Medical Society, at the Jan. 29 meeting reported on the progress in developing an advisory council for Manitowoc County which would eventually be part of the organization of the comprehensive health-planning program now being developed. The committee, when selection is completed, will be composed of 25 people, of whom at least 13 will be consumers of health services. It is believed that Manitowoc is as far along in its development of this program as other communities in the state with the exception of the large metropolitan areas.

Dr. Joseph E. C. Binard* informed the 33 members present of his attendance at the first monthly meeting of the Manitowoc County Council on Community Welfare.

The Society approved the recommendation of the Board of Health of the City of Manitowoc that the number of immunizations in the public school system be reduced by eliminating certain years for immunization. Immunizations would be given to children in kindergarten, first grade, fifth and sixth grades.

Approval of pre-school vision screening was given by the Society upon request from the Junior Service League.

HEALTH MANPOWER REPORT PRINTED

A report published recently by the National Center for Health Statistics compiles statistical information on persons employed in selected health occupations and discusses the sources of health manpower statistics.

This publication, *Health Manpower, United States, 1965–1967,* provides statistics on physicians, dental and nursing manpower, and pharmacists in relation to location, type of practice, and/or specialty. Statistics for persons employed in various occupations in hospitals and nursing homes are also presented.

Copies of this report (Public Health Service Publication No. 1000–Series 14–No. 1) may be obtained from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, at 60¢ each.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF FEBRUARY 1969

1	Finance Committee of SMS Council
3	Madison General Hospital Surgical Staff
4	Madison Urological Society
4	Madison Anesthesiology Society
4	Board of Trustees, Dane County Medical Society
5	Advisory Committee to State Alcoholism Services
5	Wisconsin Work Week of Health Planning Committee, SMS
6	Madison Inter-School Council
6	Madison Academy of Internal Medicine
8	Cardiology Study Committee, Wisconsin Regional Medical Program
10	Utilization Review Plan, Dane County Medical Society
11	Dane County Medical Society
12	*SMS Commission on Safe Transportation (Stevens Point)*
13	SMS Division on Aging
15	Committee on Government contracts, SMS Commission on Medical Care Plans
15	Board of Directors, WPS Charge Card Corp.
15	SMS Commission on Medical Care Plans
19	In-Depth Teaching Program, UW and SMS
20	Ad Hoc Committee on Nursing
21	Executive Committee of SMS Council
22	Finance Committee of SMS Council
22	Scientific Committee of SMS Council
22	SMS Council
23	SMS Council
26	Permanent Commission, Museum of Medical Progress
26	SMS Committee on Occupational Health
28	Cancer Study Committee, Wisconsin Regional Medical Program

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Dr. Marc Hansen, Director, Family Health Service

Dr. Marc F. Hansen,* of Madison has been appointed director of the University Family Health Service (UFHS).

University of Wisconsin Medical School Dean Peter L. Eichman* announced the appointment in a recent letter to the school's faculty. Doctor Hansen is assistant professor of pediatrics at the medical school.

Begun in 1966, the UFHS provides primary pediatric and obstetric care for about 1,000 families. Most of them are University of Wisconsin student families. During 1969, limited health services will become available to all family members.

Staffed by a faculty of three UW Medical School pediatricians and two obstetricians, plus interns, residents, senior medical students, nurses and a family counsellor, the UFHS is a teaching family practice.

According to Doctor Hansen, the service is designed to give students training in "the basic practices of comprehensive, preventive and family oriented medical service in an ambulatory setting. We want to interest more medical students in becoming skillful family physicians."

"Our concern," Doctor Hansen continued, "is to treat our patients in the best way, with the best skills and equipment possible, and devise the most efficient ways possible to do that. We want to make family practice attractive to more physicians."

A native of Marshfield, Doctor Hansen attended Harvard University. He received his A.B. "summa cum laude" in 1952 and his M.D. "cum laude" in 1956. After his internship at Boston City Hospital, Doctor Hansen fulfilled his residency requirements at University Hospitals in Madison.

After discharge from the U.S. Army in 1961, Doctor Hansen did post-doctoral research at the University of Wisconsin Institute for Enzyme Research. In 1963 he accepted an appointment as assistant professor of pediatrics.

In 1961 Doctor Hansen was certified by the American Board of Pediatrics. A member of the Midwest Society of Pediatric Research, he was awarded the Lederle Medical Award in 1963. The award is given to persons "who have demonstrated their capacity both as teachers and investigators" in various medical disciplines.

Doctor Hansen will be assisted in his work as UFHS director by an advisory committee of 14 distinguished members of the University of Wisconsin Medical Center.

EMERGENCY ROOM PLAN SET, WAUKESHA HOSP.

A new emergency room plan at Waukesha Memorial Hospital will begin April 1 when it will be run by a nonprofit corporation that has been formed by about 30 physicians on the hospital's medical staff.

Purpose of the move is to assure 24-hours daily attendance in the emergency room by a physician and to reduce criticism of the service.

The corporation will hire resident physicians to staff the emergency room at night. Other members of the corporation will take 4-hour tours of duty in the emergency room during which time they can have no other duties and must stay at the hospital.

Three Milwaukee hospitals have similar corporations: St. Luke's, St. Michael's, and Doctor's hospitals. According to Hospital Administrator Robert M. Jones, there are about 100 such corporations in the U.S. organized to run emergency rooms.

Officers of the corporation include Dr. Robert Bartos,* president; Dr. Raymond L. Schofield,* vice-president; Dr. Wayne Konetzki,* secretary-treasurer; and Dr. T. E. Dugan* and Dr. Alfred Kritter,* directors.

Dr. J. F. March*

. . . Algoma, was speaker at a public heart forum entitled, "The Prevention of Heart Disease," at Sturgeon Bay Jan. 28. The forum was sponsored by the Wisconsin Heart Association.

Dr. George A. Hellmuth*

. . . director of the Cardiac Work Classification Unit, Curative Workshop, Milwaukee, and associate professor of physiology, Marquette School of Medicine, has recently published the following articles:

"Comprehensive Evaluation of Heart Cases Under Workmen's Compensation," in the Number 6, 1968, issue of the *Journal of Rehabilitation*. His co-author was Dr. Glenn E. Rodey.

"Employability of Workers Handicapped by Certain Diseases," in the September 1968 issue of *Archives of Environmental Health* in the Cardiac Section.

"Heart Attack and Workmen's Compensation: Model Rules of Practice," in the January 1969 issue of the *Forum*. His co-author was Phillip J. Hellmuth.

Dr. Ben R. Lawton*

. . . in January was named president of the Marshfield Clinic, Marshfield. He succeeds Dr. Russell F. Lewis,* who was named to the executive committee. Doctor Lawton had served as vice-president for five years.

Other officers named at the annual meeting in the Clinic include Dr. Donald Pederson,* vice-president; Dr. Gerald Porter,* secretary; and Dr. Nelson Moffat,* treasurer.

Also named to the executive committee were Dr. David Ottensmeyer* and Dr. Francis N. Lohrenz.*

Dr. John Z. Bowers

. . . former dean of the University of Wisconsin Medical School, has been named national president of Alpha Omega Alpha. Doctor Bowers is president of the Macy Foundation, New York City.

A FOX FAMILY MEMBER RETIRED at the end of January after 42 years of service to the Wisconsin Life Insurance Company in Madison. The retirement of Miss Ann Fox, shown above with Donald J. Beyer, president of the company, brought to an end 74 years of continuous service to Wisconsin Life by members of the Fox family. Her father served as medical director. Miss Fox's grandfather, who also served as medical director and board member, became associated with the company when it was founded in 1895. (Photo courtesy *Madison Capital Times*)

WALWORTH DOCTORS "MEET THE PRESS"

Three Walworth county physicians formed a panel to "Meet the Press" during an event sponsored by the Walworth County Cancer Society in late January.

The audience of teenage school reporters heard Drs. Kenneth Bill* of Elkhorn, Glenn Smiley* of Delavan, and Irwin Bruhn* of Walworth reveal facts linking cigarettes to cancer.

Gundersen Foundation Gave Training to 52

During 1968, fifty-two persons participated in medical training programs sponsored by the Adolf Gundersen Medical Foundation, according to the annual report prepared by Dr. Edwin L. Overholt,* director of medical education and research.

Seven students received on-the-job training in the medical secretarial externship program. Thirteen were enrolled in the foundation's roentgen technical school. In the physician training program, eight senior medical students enrolled in the preceptor program, five physicians completed their internship, eight began their internship, four completed a year of special surgical training, one completed special training in pediatrics, two began specialty training in general surgery, and four were orthopedic surgery residents.

Students receiving training in the various programs came from the Universities of Wisconsin, Iowa, Marquette, Heidelberg, West Germany, and Oslo, Norway.

Washington Society Meets

Dr. Derward Lepley, Jr.,* Milwaukee surgeon, addressed the Jan. 30 meeting of the Washington County Medical Society on the subject of "Cardiac Revascularization Surgery." He also showed a movie of recent cardiac transplantation.

Dr. Farrell F. Golden*

. . . of Madison was among 119 radiologists who were made fellows of the American College of Radiology at the annual meeting of the College in Atlanta, Ga., Feb. 21. Doctor Golden graduated from the University of Wisconsin Medical School in 1941 and is now a member of the medical staff of Watertown Memorial Hospital, Watertown, and Divine Savior Hospital, Portage.

Dr. Roman Galasinski*

. . . is chairman of the board of the newly organized St. Francis Hospital Foundation of Milwaukee, Inc. which comprises a group of Milwaukee professional and businessmen to assist the hospital in its program of long-range development.

The Foundation will provide the means to educate the community of the needs of the modern voluntary hospital today, especially those of St. Francis, according to John C. Kadon, Whitefish Bay, the hospital's public relations counsel and executive vice-president of the Foundation.

Other physicians on the Board of Directors include Drs. Julius M. Meyer,* Wauwatosa, and Louis B. Uszler,* Milwaukee.

Arthritis

. . . Foundation has opened an information and referral office in the Neenah–Menasha area following approval of its services by the Winnebago County Medical Society.

Dr. Frederick W. Blancke*

. . . director of medical services and geriatric treatment at Mendota State Hospital, Madison recently was named director for National Health Enterprises, Inc., Milwaukee. Doctor Blancke will develop and coordinate medical and nursing programs for each of National Health's 13 facilities. He is a member of the National Council on Aging, the American Geriatrics Society, and the State Medical Society of Wisconsin's Division on Aging.

Rural Neighborhoods Get Mobile Health Unit

A self-contained mobile health unit has been put into service by the West Central Wisconsin Community Action Agency to assist economically and socially deprived persons with their health problems.

The new project was launched by the agency's Rural Health Service which includes a director, health coordinator, two registered nurses, and nine health aids, and serves a seven-county area. The mobile unit has been stationed in northeast Polk County since Dec. 3.

The Rural Health Service was organized by the agency's director, J. C. Banks, who consulted the Polk County Medical Society in setting up preliminary plans. The Society is kept informed periodically of the unit's progress through the medical consultant, Dr. Marwood Wegner.*

Personnel assigned to the mobile health unit for the trial period includes two aides, one on the unit, one in the field in the vicinity of the unit, and one registered nurse on the unit.

Experience Helpful

In describing the experiences to date and the potential services of the unit, Mr. Banks had this to say:

Visitors to the unit come for several reasons, and they can be briefly categorized as those requiring specific and immediate attention, those with long-term needs, and those who are curious about the unit. Some visitors were disappointed when the nurse informed them that a doctor was not available; others seeking routine x-rays and electrocardiograms were referred to their physician; others desired hearing and vision tests.

With experience, the aide and the nurse are developing a better understanding of their roles, and the assistance they are prepared to offer through the various functions of the West Central Wisconsin Community Action Agency, Mr. Banks stated. The nurse, especially, is aware of a growing sensitivity to the frequently unspoken needs of those who come to the unit.

It is apparent with even minimum experience in this field project, that the role of the mobile health nurse differs from that of the public health nurse, the clinical nurse, and others engaged in the nursing profession, he added.

The visitor is frequently one with multiple problems, medical, social, and economic; one who hears about the unit with its attending nurse through the local radio news, the local newspaper, or sees a poster in the neighborhood grocery store; one who seeks a bond of communication with an empathetic person.

This person, in the environment of his own community, relates to the nurse, who tries to develop avenues of communication in which he expresses concern, and hopefully, to find means of assistance. With transportation available, the nurse can readily arrange for referral to physicians, State Social Service and Public Health Nursing, or other aid, Mr. Banks explained.

If a situation arises, which in her nursing experience she interprets as an acute health need, she arranges for him to see the doctor of his choice. If she discovers that the individual is unable to meet such expense she includes in the referral a statement that West Central Wisconsin Community Action Agency will assure payment for the first visit and for medication. Such emergency services have been valuable in returning a wage earner to gainful employment, and in the early control of fulminating illnesses.

Physicians appreciate the simple referral form which helps in billing for the service, as well as the efforts of the agency to bring the individual to medical attention and care, he noted. Through this method of referral other physicians have become acquainted with some of the goals of the mobile health unit.

Health Mobile Unit

Interior View

At present the Rural Health Service is primarily concerned in its mobile unit with family health appraisal and the identification of needs. These are reflected from a sampling of target families in areas in which the unit is operating.

Neighborhood Service

Another aspect in planning is rescheduling the unit for each area on a regular basis, thus permitting it to become a neighborhood service. It is hoped that a bond will be established through repeated visits to the area; that the friendly, empathetic approach on the part of aides and nurses, through services rendered in the neighborhood area, may be welcomed by the target group, Mr. Banks emphasized.

continued on next page

MOBILE HEALTH UNIT
continued

The Rural Health Service hopes to project further expansion of its services on evaluation of these surveys, as well as on the services rendered through referrals, immediate care, and opportunities for health information to be distributed on a one-to-one basis and through the neighborhood groups contacted.

Questions that arise and for which survey work may assist in giving answers are: the number of mothers not seeking prenatal and postnatal care in a locality and their reasons for failing to seek such care; why many people have long periods between a visit to the doctor or to the dentist; whether protection of health through immunization procedures is at a safe level in isolated rural areas; whether there is a need for well-child clinics; whether there is a need for a dental clinic to assess needs, particularly in areas some distance from dental services.

Can the mobile health unit assist the target group in getting services which will raise and maintain a higher level of health? Can it also promote health education activities which will raise and maintain a higher level of health in this group?

Mr. Banks concluded: This is the challenge which the Mobile Health Service of the West Central Wisconsin Community Action Agency is seeking to meet. It is not a challenge which the agency defines but one which is defined by the unspoken needs of every man, woman, and child in the area. It is a challenge to all civic and professional groups to cooperate in meeting the needs of those who through misfortune, limitation of education, illness, and many other causes, are in the endless cycle of sickness breeding poverty and poverty breeding sickness.

The West Central Wisconsin Community Action Agency is federally supported through the Office of Economic Opportunity program and has its headquarters at Menomonie.

CONTRIBUTIONS—CES FOUNDATION

January 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for January 1969:

Nonrestricted

Monroe Clinic–Green County Medical Society	Voluntary contribution
Mr. and Mrs. Herman Toser	Memorial: Mrs. John Siebert
Wisconsin Physicians Service	Memorial: James T. Williams
E. E. Bryant	Memorial: William Vilas Bryant, MD
Dr. and Mrs. Robert Schmidt	Memorial: I. E. Levitas, MD
State Medical Society	Memorial: Herman L. Shapiro, MD
	Memorial: Harry G. Walters, MD
	Memorial: Walter J. Jones, MD
	Memorial: John J. Zaun, MD
	Memorial: Robert H. Smuckler, MD
Woman's Auxiliary to Brown County Medical Society	Memorial: Mrs. R. S. Schmidt

J. G. Crownhart Memorial Account

Mr. and Mrs. Warren Turner, Jr.	
C. H. Crownhart	Memorial: Mrs. David J. Clark
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Danforth Student Loan Fund

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Mr. and Mrs. Ralph Anderson	Memorial: Mrs. David J. Clark

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Mr. and Mrs. Joseph Werner	Memorial: George A. Benish
Mrs. Marion Darbo	Memorial: George A. Benish

W. W. Hildebrand Memorial Account

William B. Hildebrand, M.D.

RURAL HEALTH TEAM SURVEYS FOUR COUNTIES

A rural health team of the Wisconsin Coulee Region Action program—with headquarters at Viroqua—began operations in January to survey the health and related needs of the four-county regions of Monroe, Crawford, La Crosse, and Vernon.

The team is composed of ten aides, a social worker, and a nurse. Contained in the rural health program of the agency are the positions of medical consultant and legal aid. Dr. P. T. Bland* of Westby is medical consultant.

The team works with a mobile unit where people are invited to visit and discuss any problem with the nurse and the social worker.

Funds for the project come from the federal Office of Economic Opportunity.

Named Delegates to NABSP

Drs. David N. Goldstein,* Kenosha, and William T. Casper,* Milwaukee, have been reappointed to serve as voting delegates for the National Association of Blue Shield Plans representing Wisconsin Blue Shield (WPS). Both are members of the State Medical Society's Commission on Medical Care Plans which appointed them.

Narcotic Addict Convicted for Posing As Doctor

A 47-year-old Spencer man, Robert Pilz, pleaded guilty in Circuit Court in Lancaster Jan. 27 to four charges stemming from his posing as a doctor in Lancaster in December.

Judge Richard Orton sentenced Pilz to one year in prison on a charge of practicing medicine without a license, 15 months in Waupun State Prison at hard labor for obtaining drugs while posing as a physician, and two terms of not more than 15 months for supplying a patient with a dangerous drug and using narcotics not prescribed by a doctor.

Pilz, who assumed the name of an Iowa doctor, Francis Slattery, posed as a doctor in the office of Lancaster physician, Dr. Elgie M. Houghton,* who was led to believe that he was a licensed physician.

He saw several patients in the two days he practiced and generally prescribed Demerol. His strange medical techniques were noted by those with whom he came in contact and a representative of the Wisconsin State Medical Examining Board was called in to investigate.

During the trial a physician testified that Pilz is an incurable narcotic addict. Judge Orton, in sentencing Pilz, noted that he had been in every institution in the state, including Central State Hospital at Mendota, and three times in Winnebago.

BROWN SOCIETY HONORS APPLETON REPORTER

An Appleton Press–Gazette staff writer, Sarah Alden, received the 1968 Medical Service Award presented by the Brown County Medical Society at a luncheon Jan. 28.

Dr. L. H. Edelblute,* chairman of the awards committee for the Society, said:

"As the Press–Gazette staff writer assigned to coverage of medical affairs, Miss Alden has done an outstanding job of presentation of medical problems and health affairs over a period of several years. Her diligent research, accurate reporting, and depth of understanding have contributed greatly to the health of her community through dissemination of vital information. . ."

Heart Association Produces TV Specials in February

Two television specials were produced by the Wisconsin Heart Association and shown 13 times on 12 television stations in Wisconsin during February—Heart Month.

The specials featured two Milwaukee physicians, Dr. Derward Lepley, Jr.* and Dr. Ross C. Kory.* Doctor Lepley is the heart surgeon who headed the team which performed the first heart transplant in Wisconsin. Doctor Kory is president of the Wisconsin Heart Association.

Both programs included films on risk factors. Persons in the local community active in the work of the WHA gave messages during the programs.

SE WISCONSIN MEDICAL CENTER COUNCIL FORMED

The 15-member governing body (council) of the proposed medical center for southeastern Wisconsin held its first meeting in mid-January at the Milwaukee County courthouse with County Executive John P. Doyne presiding.

Elected temporary chairman was D. C. Jacobus, president of the Jacobus Co. He had headed a steering committee that developed the structure for a medical center.

A corporation called Southeastern Wisconsin Medical Foundation has been formed to comply with legal requirements in developing and operating a medical center. Council members make up its board of directors.

ST. FRANCIS HOSPITAL, MILWAUKEE, OPENS NEW CORONARY CARE UNIT

St. Francis Hospital's new $100,000 Coronary Care Unit, (3237 South 16th St., Milwaukee, Wis.) equipped and staffed for specialized treatment to heart attack victims and heart disease patients, was opened in Milwaukee in February. Dr. Julius M. Meyer* heads the new project.

Specialists in internal medicine follow an "on-call" schedule with a specialist always available for an emergency. Dr. Merlin Kottke* is chairman of the committee.

Specially-trained nurses staff the four-bed unit—one registered nurse for each two patients. Each patient is monitored continuously from time of admission until transfer from the unit.

The unit is completely equipped to handle any emergency and all emergency drugs are immediately available.

DR. J. J. SUITS HEADS WOOD MEDICAL SOCIETY

At the Jan. 16 meeting of the Wood County Medical Society Dr. J. J. Suits* of Marshfield was elected president; Dr. N. W. Arendt,* Wisconsin Rapids, vice-president; and Dr. J. J. Mulvaney,* Marshfield, secretary-treasurer. Elected delegates to the State Medical Society were Drs. R. F. Lewis,* Marshfield, and E. C. Glenn,* Wisconsin Rapids; alternate delegates, Drs. N. A. Moffat,* Marshfield, and A. W. Hulme,* Wisconsin Rapids.

During the business session reports were presented by Drs. J. J. Mulvaney,* L. R. Pfeiffer,* and J. R. Heersma.*

Heads Dane Cancer Drive

Dr. William D. Stovall* of Madison has been appointed 1969 Dane County chairman for the annual Cancer Society Crusade.

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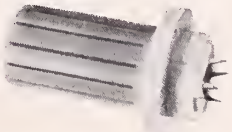

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OBITUARIES

Dr. John J. Zaun, 64, former Milwaukee physician, died June 9, 1968, in Phoenix, Ariz.

He was born on Nov. 29, 1903, in Milwaukee and graduated from the Marquette University school of Medicine in 1930 and interned at St. Mary's Hospital, Milwaukee. Doctor Zaun practiced in Milwaukee until 1961 when he retired and moved to Arizona.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Sally; a son, Jay, and two daughters, Mrs. Dorothy Schneider and Mrs. Carol Ellsworth, Oconomowoc.

Dr. Russell C. Smith, 65, former Barron physician and surgeon, died Sept. 8, 1968, in Seattle, Wash.

Doctor Smith graduated from the University of Wisconsin Medical School in 1929, interned at Iowa State University and entered graduate training at Barnes Hospital, Washington University, St. Louis, Mo. Doctor Smith practiced at Barron, Wis., from 1931 to 1951 and then went to Petersburg, Alaska. He was a member of the Industrial Medical Association and was an official of the Alaska Heart Association.

Surviving is his widow, Mary.

Dr. Frederick A. Leighton, 75, a physician and surgeon at Sheboygan Falls for 38 years, died Oct. 15, 1968, in Sheboygan.

Born in Waukesha in 1893, Doctor Leighton attended the University of Wisconsin and received his medical degree in 1926 from the University of Minnesota. He came to Sheboygan Falls in 1927 and practiced there until his retirement in 1965 when he moved to Sheboygan. He was justice of the peace and health officer from 1930–1933, mayor from 1933–1935 and active in the Board of Education. He served as medical director of the Sheboygan County Hospital from 1945–1956 and was county physician from 1951 to 1966. Doctor Leighton served in the United States Army medical corps during World War I.

He was a member of the Sheboygan County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving is one son, Richard C., Cedar Rapids, Iowa; and three daughters, Mrs. William (Janet) Glidden, Waukesha, Constance L., Atlanta, Ga., and Michele A., Sheboygan.

Dr. Samuel A. Freitag, 68, well known Janesville physician and senior partner associated with Pember–Nuzum Clinic, died Oct. 23, 1968, in Janesville.

Doctor Freitag was born on May 25, 1900, in New Glarus, and graduated from the University of Wisconsin Medical School in 1926 and Rush Medical College, Chicago. He was a resident physician at Cook County Hospital, Chicago, before locating in Janesville. Doctor Freitag served in the United States Army during World War II and was discharged in 1945. He was a longtime member of the Mercy Hospital staff, Janesville, and was named chief-of-staff and president in 1960. In 1964, he was appointed to the Commission on Public Policy of the State Medical Society of Wisconsin.

Doctor Freitag was a member of the American College of Surgeons, North Central Branch of American Urological Society and was certified by the American Board of Urologists. He was a member and past president of the Wisconsin Urological Society and a member of the Rock County Surgical Society.

He was a member of the Rock County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Alice; and a son, John S., with the U.S. Naval Oceanographic Department in Washington, D. C.; and a daughter, Mrs. David Croft, Seattle, Wash.

Dr. Joseph W. Gale, 68, senior thoracic surgeon at University Hospitals, Madison, died Oct. 26, 1968, in Madison.

Born in Milton, Ia., on Jan. 21, 1900, he had been a Madison resident for the past 40 years. Doctor Gale graduated from Washington University Medical School, St. Louis, Mo., in 1924 and took his internship and residency at Barnes Hospital, St. Louis. He was a veteran of World War I and World War II.

In 1966, Doctor Gale became the first surgeon to receive the annual Distinguished Service Award of the Wisconsin Anti-Tuberculosis Association. A founding member of the American Board of Surgery, Doctor Gale recently had been named to a temporary three-man committee to run the University of Wisconsin Medical School surgery department.

Doctor Gale was a member of the American Surgical Association, American Association for Thoracic Surgery, Central Surgical Association, Society of University Surgeons, Wisconsin Surgical Society, Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are two daughters, Mrs. Michael McPhee, Arlington Heights, Ill., and Mrs. David Mayer, Denver, Colo.

DR. SAMUEL A. FREITAG

A physician and surgeon has opportunities every day to help his fellow man, and many go unheralded for their continuing service. Dr. Samuel A. Freitag, who died this week after a lengthy illness, was well known for his professional healing, but the long record of his service to his country and to the community was a surprise to many.

His specialty was urology, but Dr. Freitag went beyond the call of duty in surgery, in his World War II tour of duty on the battlefield and in tending the ills of his patients here.

The community is better for his contributions, both in health and in civic leadership. It will sorely miss the ministrations of "Dr. Sam."

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JANESVILLE GAZETTE, Oct. 26, 1968

Dr. John J. O'Hara, 72, former Milwaukee physician died Nov. 5, 1968, in Oconomowoc.

Doctor O'Hara was born Aug. 8, 1896, and graduated from Marquette University School of Medicine in 1921 and interned at St. Joseph's Hospital, Milwaukee. He was a veteran of World War I. For the last seven years he was on the staff of Rogers Memorial Hospital, Oconomowoc.

He was a member of the Waukesha County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Florence; and two children, John M. O'Hara and Mrs. David (Mary) Carew.

Dr. Homer H. Morton, 83, Dodgeville physician since 1928, died Nov. 11, 1968, in Dodgeville.

Born in Richland Center on Feb. 21, 1885, he graduated from Marquette University School of Medicine in 1908 and started his practice in Cobb the same year. In 1927, he studied in the clinics of Copenhagen, Denmark, and Vienna. In 1928, he moved his offices to Dodgeville. He was an institutional physician at the Iowa County Hospital and Home and practiced for 54 years until hospitalized in 1962.

In 1958, Doctor Morton was honored by the State Medical Society of Wisconsin for 50 years of service to the community and in 1962 he became a member of the Fifty-year Club of the Society. He was a member of the Iowa County Medical Society, American Medical Association, and a life member of the Medical Society of Vienna, Austria.

Surviving are his widow, Gertrude; and two daughters, Mrs. Edith Stebnitz, Chicago, Ill., and Mrs. Carla Schill, Dodgeville; and a sister, Mrs. Eva Grape, Richland Center.

Dr. Robert H. Smuckler, 71, Milwaukee physician, died Nov. 12, 1968.

Born on Dec. 24, 1897 in Marshfield, Doctor Smuckler graduated from Rush Medical College in 1922 and interned at Mt. Sinai Hospital, Milwaukee. He established a general practice in Milwaukee and was a part-time school physician.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

He was married and had two children.

Dr. Gregory G. Shields, 61, Wisconsin Rapids, died Nov. 12, 1968, in Marshfield.

Born in Milwaukee on Aug. 6, 1907, Doctor Shields graduated from the Marquette University School of Medicine in 1932 and interned at Milwaukee County General Hospital. He established his practice in Abbotsford and served in that area until being named district health officer in 1952 when he moved to Wisconsin Rapids.

Doctor Shields was a past president of the Wood County Medical Society and the Wisconsin Public Health Association, serving in the former capacity in 1962 and the latter in 1961–62. He was a member of the American Association of Public Health Physicians, a fellow of the American College of Preventive Medicine, and a member of the Wisconsin Health Council, American Medical Association and the State Medical Society of Wisconsin.

Surviving are his widow, Blanche; two sons, Frederick, Lombard, Ill., and Patrick, with the Navy at Great Lakes; and a daughter, Mrs. David Kurz, Lakehurst, N.J.

Dr. F. J. Gillette, 63, former Mondovi physician, died Nov. 13, 1968, in Temple, Tex.

Doctor Gillette was born on Jan. 5, 1905, at Necedah, graduated from Harvard Medical School in 1930 and served as a naval physician for 10 years. He practiced in Mondovi for a few years and then moved to Texas where he was associated with the Veterans Hospital.

Surviving are his widow; one son, F. J. Gillette, Jr., Waco, Tex.; and one daughter, Mrs. James Trowbridge, Temple, Fla.

Dr. Eugene C. Heifetz, 66, a Milwaukee physician for 40 years, died Nov. 15, 1968, in Milwaukee.

Born in Lithuania on Dec. 25, 1901, Doctor Heifetz came to Milwaukee in 1908. He graduated from the Marquette University School of Medicine in 1927 and interned at Milwaukee County General Hospital. He also graduated from Marquette University Law School in 1936. Doctor Heifetz was a former chief of staff of St. Anthony Hospital and was a staff member of Doctors and Mount Sinai Hospitals. His offices were at 4838 West Fond du Lac Avenue.

He was a member of the American Academy of General Practice, a charter member of the National Cystic Fibrosis Research Foundation, and the Wisconsin Heart Association.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Selma and two daughters, Mrs. Elliot Gross, New York City and Diane J., Shorewood, Wis.

Dr. M. Alex Krembs, 57, Milwaukee obstetrician and gynecologist, died Nov. 19, 1968, in Milwaukee.

Born on Dec. 30, 1910, Doctor Krembs graduated from Rush Medical College, Chicago, Ill., in 1939 and interned at Milwaukee County Hospital. He did three years postgraduate work at St. Luke's Hospital, Chicago, and was also an instructor at Northwestern University. Doctor Krembs served in the United States Navy during World War II and was the first medical officer to go back to Corregidor when the amphibious forces landed there. He is the holder of the Silver Star. He retired from active practice in December 1967.

Doctor Krembs was a diplomate of the American Board of Obstetrics and Gynecology; fellow, American College of Surgeons; fellow and section chairman, American College of Obstetricians and Gynecologists; member, Central Association of Obstetricians and Gynecologists, Wisconsin Society of Obstetrics and Gynecology, Milwaukee Academy of Medicine; and a member and past president of the Milwaukee Gynecological Society.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Ann; two sons, Alex W. and John T.; and two daughters, Mrs. Mary Stento and Elizabeth C.

Dr. Edward T. Hougen, 59, former Sheboygan physician, died Nov. 22, 1968, in North Ridge, Calif.

Born Dec. 8, 1908, in Wisconsin Rapids, Doctor Hougen practiced in Sheboygan from 1940 to 1962. He moved to California because of ill health. Doctor Hougen graduated from the Northwestern University Medical School in 1933 and interned at Milwaukee County Hospital. He served for two years in the United

States Army Air Force medical corps during World War II.

Surviving are his widow, Mildred; and two sons, Dr. John, Washington, D.C., and the Rev. Edward T., South Hadley, Mass.; and a daughter, Mrs. Kenneth (Helen) Carpenter, Denver, Colo.

Dr. D. R. Notbohm, 75, Fort Atkinson, died Nov. 29, 1968, in Fort Atkinson.

Doctor Notbohm was born in 1893 in Delafield, graduated from Loyola Medical School in 1916 and served overseas in World War I with the Medical Corps. He practiced in White Lake for 20 years before moving to Ft. Atkinson in 1943. Doctor Notbohm retired from practice in 1963.

Surviving are his widow, Matilda, and one son, Col. William R., Newport News, Va.

Dr. Edgar Thomas, 78, Milwaukee physician, died Dec. 5, 1968.

Born July 2, 1893, Doctor Thomas graduated from Howard University, Washington, D.C. and interned at City Hospital, St. Louis, Mo. Doctor Thomas had been in practice for more than 40 years in Milwaukee and at one time headed the NAACP chapter in Milwaukee.

Surviving are four daughters; Mrs. Mildred Madison, Cleveland; Mrs. Winifred Caroway, San Francisco; Mrs. Constance Henderson, Tokyo, and Dr. Anna Standard, Washington, D.C.

Dr. Frederick Jackson Stoddard, 54, a nationally recognized Milwaukee obstetrician and gynecologist, died Dec. 7, 1968, as the result of injuries sustained while trying to avoid a tree which was being cut down on his farm property five miles south of Slinger.

Doctor Stoddard was part of a four-generation Wisconsin medical family: his father, Charles H., grandfather, Charles L., and his son, Frederick J., Jr., an intern. A portion of the Stoddard family history appears in an editorial on the opposite page.

Dr. Jack Stoddard was born Jan. 28, 1914, in Milwaukee where he attended Milwaukee County Day School and received his BA degree from Bowdoin College, MA from the University of Wisconsin, and MD from the University of Pennsylvania in 1939.

He took his internship and residency at the University of Michigan. After serving two years in the Navy, he returned to Milwaukee in 1946 and established a private practice.

In addition to his private practice, Doctor Stoddard served as clinical professor at Marquette medical school where he twice was voted the outstanding clinical professor. He initiated and was in charge of the gynecologic–endocrine clinic at Milwaukee County General Hospital. He had served as chairman of his department in both Columbia and Lutheran hospitals of Milwaukee and was on the Governing Board of Lutheran Hospital at the time of his death.

He was a past president of the Milwaukee Academy of Medicine, secretary of the Milwaukee Surgical Society, president of the Travel Club of the Central Association of Obstetricians and Gynecologists, and a founder and past president of the Milwaukee Gynecological Society. He was a charter member of the new Society for the Study of Reproduction and the Milwaukee Civil War Round Table.

He was a member of the American College of Obstetrics and Gynecology, Central Association of Obstetricians and Gynecologists, and the Wisconsin Obstetrical Society and the scientific honorary Sigma Xi.

Doctor Stoddard was a board member of the Milwaukee Psychiatric Services and had served in this capacity on the Children's Service Society. He helped organize the first professional division for the Community Fund Drive (now known as United Community Services) and headed the professional solicitation for the Cancer Society in 1960. He had served on the Board of Milwaukee Downer Seminary until it melded to become part of the University school and had served on the Alumni Council of Bowdoin College.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

He is survived by his widow, Annette; a son, Dr. Frederick J., Jr., New Haven, Conn.; four daughters, Ann, Eloise, Mary, and June, all at home; and a brother, Charles H., Duluth, Minn.

Dr. Harry G. Walters, 77, Racine physician for more than 30 years, died Dec. 21, 1968, in Racine.

Doctor Walters was born Mar. 26, 1891, in Milwaukee and graduated from Marquette University School of

A FEW TRIBUTES RECEIVED BY THE FAMILY

F. JACKSON STODDARD, MD: 1914–1968

"In the death of your husband, Milwaukee lost its finest Man of Medicine. No one ever gave more of himself to his friends, his profession, and his community . . . His influence will always live on."—EDWARD A. BACHHUBER, MD, President, Milwaukee Academy of Medicine

"He was such a forceful personality that even though he won't be physically present his forthrightness, integrity, and all those other fine qualities that represent the good in man will continue to be remembered and live in those who knew him. I know, for our association began twenty-four years ago when I was a lowly intern, and I am a better person as a result."—JAMES KRIEGER, MD, Cleveland Clinic

"Jack made dull days interesting, hormones human, and gynecology less of a science and more of an excursion into humanity . . . Nobody has ever impressed me as the consummate combination of the clinician and the teacher as Jack. He showed so many of us the woman a good deal north of gynecology."—CHARLES W. HENDERSON, MD, Detroit, Mich.

". . . so competent and compassionate . . . he was my doctor and my friend."—A PATIENT

"I will never forget his kindness and his thoughtfulness over the many years I was his patient . . . He touched so many lives . . . It was an honor to know him."—A PATIENT

"He had that very rare quality of vision and creativity which every organization needs to be good and great. Jack gave more than his share of this to Columbia."—CARLTON P. WILSON, President, Board of Directors, Columbia Hospital, Milwaukee

Medicine in 1921. He was also a graduate of the Wisconsin Engineering School. Doctor Walters practiced in Cedarburg before coming to Racine in 1929. He was on the medical staff of St. Luke's Hospital, Racine.

Doctor Walters was a member of the Racine County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are three daughters, Mrs. James Smith, Racine, Mrs. William Stroemer, McClain, Va., and Mrs. John Falbe, San Pedro, Calif.; and two sons, Pierce, Washington, D.C., and Neil, Milwaukee.

Dr. Walter J. Jones, 76, La Crosse physician for 46 years, died Dec. 26, 1968, in La Crosse.

He was born on May 13, 1892, in Rockland and received his medical degree in 1917 from the University of Pennsylvania. He interned at Harlem Hospital, New York, and served as an officer in the United States Army Medical Corps.

Doctor Jones was a member of the Central States Society of Industrial Medicine and Surgery and a fellow of the American Association of Industrial Physicians and Surgeons. He was a member of the La Crosse County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Leona; and three sons, William, Brigham City, Utah; John, Memphis, Tenn.; and Edward, La Crosse. □

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AN EDITORIAL

The Stoddards—A Four-Generation Wisconsin Medical Family

THE UNTIMELY DEATH of Dr. Frederick Jackson Stoddard of Milwaukee calls attention to a four-generation Wisconsin medical family.

Doctor Stoddard's father, Charles H., and his grandfather, Charles L., practiced medicine in Wisconsin, and his son, Dr. Frederick J. Stoddard, Jr., is now an intern. Dr. Charles H. Stoddard was a leading Milwaukee internist.

Doctor Charles L. Stoddard is noted in medical history as the physician responsible along with Dr. Erastus B. Wolcott for performing the first nephrectomy on a human-being June 4, 1861 (International Abstract of Surgery, February 1929, pp. 103–106).

Doctor Charles H. was born in East Troy in 1870 in a house that is still in use. He graduated from the University of Wisconsin and Illinois Medical College, and took his internship at Michael Reese Hospital. He did postgraduate work in Vienna and Strasbourg. Doctor Charles H. was a president of the Wisconsin Anti-Tuberculosis Association and aided in founding Columbia Hospital at a time when hospital laboratories were becoming important. He, too, was a past president of the Milwaukee Academy of Medicine, as was Dr. Jack, and was chief of the Department of Medicine at Columbia Hospital. Like Doctor Jack he was a noted 'raconteur.' Doctor Charles H. died in 1941.

Doctor Charles L. was born in Buffalo in 1836 and attended the Pennsylvania Medical College in Philadelphia from which he graduated in 1860, subsequently serving a residency at Philadelphia General Hospital (Blockley) before coming to Wisconsin.

The family version of the first nephrectomy follows:

> "Dr. C. L. had an extremely ill male patient and decided that major surgery was indicated so he made a trip (by horseback or on foot?) to Milwaukee from East Troy to obtain the services of Dr. Wolcott, a well-known surgeon. (As we know the story) Dr. Wolcott journeyed to East Troy on foot where the two physicians removed the diseased organ which later proved (on examination) to be a kidney. Thus the first nephrectomy recorded in medical history was performed. The patient expired 15 days later but that he lived at all was remarkable at the time."

Dr. C. L. was interested in chest disease as was Dr. C. H. but Jack used to laugh as he told how his grandfather never could believe that that little bacillus squiggling under a microscope could cause such a dread disease, "it was too little."

So Jack came to medicine with a love for the profession born of strong family dedication and tradition. A speech he delivered to the Marquette medical school student body at the time he received the Phi Chi teaching award in 1956 reveals his idealism and understanding of what a physician should be. ("An Informal Credo," Marquette Medical Review, vol. 22, no. 1, 1956, pp. 1–5)

Dr. Jack Stoddard's maturity and balance were not accidental. He sought perspective by getting away: on hunting trips to his brother Chuck's place near Minong each fall. With boyish anticipation the trip gained in enjoyment despite fewer 'birds' each year; to a summer home in Algonquin Park where wood chopping, carpentry projects, and no telephone were favorite features, to return refreshed with new ideas and enthusiasm.

He made a habit of going to the Marquette Medical Library regularly to go over recent publications and keep up with research touching obstetrics, gynecology, and endocrinology. This study was eased by the able assistance of Miss Mary Dougherty of the Milwaukee Academy of Medicine. In this way he wrote his book, "Case Studies in Obstetrics and Gynecology," published in 1964 and now in the process of revision, and many scientific articles.

The high esteem in which he was held by his colleagues, friends, and patients is reflected in the tributes which appear on the opposite page along with his obituary.

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IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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continued next page

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1969 WISCONSIN

Apr. 25–26: Annual meeting, Wisconsin Urological Society, Holiday Inn—Mid Town, Milwaukee.

May 1: Jackson Clinic and Foundation Spring Postgraduate Meeting, Park Motor Inn, Madison.

May 2: Annual spring meeting, Wisconsin Association on Alcoholism, Pfister Hotel, Milwaukee.

May 5–7: Annual session, Wisconsin State Dental Society, Milwaukee Auditorium, Milwaukee.

May 7: Projected Clinics, Wisconsin State Dental Society.

May 10–11: Midwest Anesthesiology Resident Meeting, Wisconsin Center, Madison.

May 11: State Medical Society Council meeting, Hotel Sheraton-Schroeder, Milwaukee.

May 12–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 14: State Medical Society Council meeting, Hotel Sheraton-Schroeder, Milwaukee.

May 14–16: Annual Conference, National Society for the Prevention of Blindness, Pfister Hotel, Milwaukee.

May 15: Annual Meeting, Wisconsin Surgical Society, in conjunction with the Annual Meeting of the State Medical Society of Wisconsin, Milwaukee.

June 5–7: Conference on "The New Hospital Psychiatry," sponsored by the University of Wisconsin Department of Postgraduate Medicine, Department of Psychiatry, and the Wisconsin Psychiatric Institute of the University of Wisconsin Medical Center, Madison.

June 9: UW graduation day.

June 15: President's Reception, State Medical Society, Madison.

Aug. 2–3: State Medical Society Council meeting.

Sept. 11–14: Annual Meeting, Wisconsin Society of Internal Medicine, Deer Park Lodge, Land O'Lakes.

October: Wisconsin Work Week of Health, State Medical Society, Madison.

Oct. 3–4: Annual meeting, Easter Seal Society of Wisconsin, Beaumont Motor Inn, Green Bay.

Oct. 8–9: Annual meeting, Wisconsin Academy of General Practice, Holiday Inn No. 2, Madison.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton-Schroeder Hotel, Milwaukee.

1969 NEIGHBORING STATES

Apr. 24–26: 31st Annual Session, American Academy of Physical Medicine and Rehabilitation, Sheraton-Chicago Hotel, Chicago.

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

June 10–13: Annual convention, Catholic Hospital Association, Minneapolis, Minn.

Sept. 15–16: Biennial meeting of State Medical Journal Advertising Bureau, Chicago, Ill.

Sept. 22–23: Midwest Interprofessional Seminar on Diseases Common to Animals and Man, Memorial Union, Iowa State University, Ames.

Nov. 8–9: North Central Medical Conference, St. Paul Hilton, St. Paul, Minn.

Nov. 30–Dec. 5: Radiological Society of North America, Chicago, Ill.

1969 OTHERS

May 8–10: National Conference on Breast Cancer, American Cancer Society, Shoreham Hotel, Washington, D.C.

May 12–16: ACP postgraduate course—Internal Medicine, University of Pennsylvania School of Medicine (Pennsylvania Hospital), Philadelphia, Pa.

May 18–21: Annual Meeting, Pharmaceutical Manufacturers Association, The Greenbrier, White Sulphur Springs, W. Va.

June: AHA Council on Clinical Cardiology, title and location to be announced.

June 9–13: ACP postgraduate course—Neurology for the Internist, Bowman Gray School of Medicine, Winston-Salem, N.C.

June 16–19: ACP postgraduate course—Auscultation of the Heart, University of Oregon Medical School, Portland, Ore.

June 15–20: Lecture series, Flying Physicians Association, Lake Placid Club, Essex County, New York.

June 16–20: ACP postgraduate course—Hematology, University of Rochester School of Medicine, Rochester, N.Y.

July 7–11: Postgraduate Course—Clinical Electrocardiographic Interpretation, Hahnemann Medical College and Hospital, Philadelphia, Pa.

July 14–18: Postgraduate course—Interpretation of Cardiac Arrhythmias, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 11–15: American Bar Association, Dallas, Tex.

Aug. 11–17: Postgraduate course—Space Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 14–16: Postgraduate course on Peptic Ulcer, American Gastroenterological Association, Aspen, Colo.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 28–Oct. 3: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 7–11: Western Conference of Prepaid Plans, Sun Valley, Idaho.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

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MEDICAL MEETINGS *continued*

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Nov. 20: Annual Membership Meeting, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psycosomatic Seminars), to South Pacific.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1969 AMA

July 13–18: Annual meeting, American Medical Association, New York City.

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

May 11–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1970 OTHERS

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

1971 OTHERS

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Seminar on Diseases, in Iowa

The 11th annual Midwest Interprofessional Seminar on Diseases Common to Animals and Man will be held Sept. 22–23 at the Memorial Union, Iowa State University, Ames, Iowa. Dr. Vaughn A. Seaton, Professor and Head, Veterinary Diagnostic Laboratory, College of Veterinary Medicine, Iowa State University, Ames, Iowa 50010, is chairman.

"New Hospital Psychiatry" Program

The University of Wisconsin Department of Postgraduate Medicine, the Department of Psychiatry, and the Wisconsin Psychiatric Institute of the University of Wisconsin Medical Center will sponsor a two and one-half day conference, June 5–7, devoted to the theme "The New Hospital Psychiatry."

This conference will be directed toward mental health professionals who are intimately involved in inpatient care and will emphasize innovative developments in the clinical operations of hospital psychiatry settings.

Some of the featured speakers will be Gene Abroms, MD, Teodoro Ayllon, PhD, Frederick Duhl, MD, Richard Grant, MD, Henry Grunebaum, MD, Nathan Kline,

MD, Arnold Ludwig, MD, David Sanders, PhD, George Saslow, MD, and Carl Whitaker, MD.

For further information write: Thomas C. Meyer, MD, Chairman, Department of Postgraduate Medicine, 307 N. Charter St., Madison, Wis. 53706.

AMA's 1969 Annual Convention

An abundance of valuable information will be presented in a variety of interesting ways to those attending the American Medical Association's 1969 Annual Convention in New York City.

Some information will be available to visitors in the comfort of their convention hotels or motels. This will be through the special televising of convention news, interviews, panels, and scientific presentations.

Such TV programming, a highlight of AMA Annual and Clinical conventions in recent years, will be available from 5 p.m. to midnight Sunday, July 13; from 7 a.m. to 9 a.m. and from 5 p.m. to midnight Monday through Wednesday, July 14 through 16; and from 7 a.m. to 9 a.m. Thursday, July 17.

Much of the scientific activity of the July 13 through 17 Annual Convention will be in the Coliseum and New York Hilton Hotel. The House of Delegates will meet at the Americana Hotel.

In addition to papers and lectures which will be presented in the Coliseum and New York Hilton, there will be exhibits, color closed-circuit television, and medical motion pictures.

Some 250 to 300 scientific exhibits are expected at the Coliseum, including special ones on arthritis, pulmonary function, fresh tissue pathology, fractures, resuscitation, and laboratory medicine.

Industrial exhibits also will be on view at the Coliseum.

From rooms set aside at the Coliseum, viewers will be able to see closed circuit scientific presentations televised in color from Cornell University Medical Center.

The Coliseum also will be the site of medical film showings, including the premiere showing of some new films.

Peptic Ulcer Course, Colorado

A postgraduate course on Peptic Ulcer is being sponsored by the American Gastroenterological Association Aug. 14–16 at Aspen, Colo. Course chairman: Morton I. Grossman, MD. Contact: AGA Postgraduate Course, P.O. Box 20056, Denver, Colo. 80220.

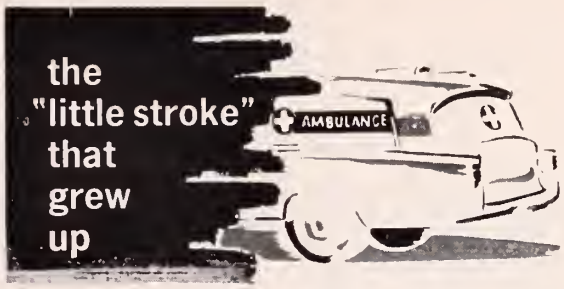
Flying Physicians Association

The 15th annual meeting and lecture series of the Flying Physicians Association will be held June 15–20 at the Lake Placid Club, Essex County, New York.

As in the past, this year's meeting will emphasize the FPA's primary objective of promoting general aviation safety through example and teaching.

Top authorities in aviation safety and aerospace medicine will address the doctor–pilots. During round table discussions, members will exchange views and experiences on such subjects as instrument flying, weather, and maximum aircraft performance.

A portion of this year's program will be devoted to highlighting the samaritan activities of the FPA. An increasing number of members are volunteering to serve in humanitarian projects throughout the world.



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[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953

[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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1969 ANNUAL MEETING

STATE MEDICAL SOCIETY OF WISCONSIN

MAY 11–15 — MILWAUKEE AUDITORIUM

AND HOTEL SHERATON–SCHROEDER

Program Highlights

SUNDAY, MAY 11

Noon—Council luncheon; **P.M.**—Council meeting; **Evening**—Fifty-Year Club dinner.

MONDAY, MAY 12

Noon—Board of Directors meeting of Wisconsin Academy of General Practice.

Evening—Buffet supper for Delegates and Officers; First Session of House of Delegates.

TUESDAY, MAY 13

A.M.—PACE breakfast; reference committee meetings; Internal Medicine scientific program.

Noon—Clinic managers luncheon; scientific luncheons featuring Internal Medicine, Pathology, Radiology, Public Health, and Surgery.

P.M.—Scientific programs featuring Internal Medicine, Pathology, Radiology, and Utilization Review; Wisconsin Radiological Society business meeting.

Evening—Marquette Medicial Alumni dinner; Wisconsin Radiological Society dinner; Second Session of House of Delegates.

WEDNESDAY, MAY 14

A.M.—Catholic Physicians Guild breakfast; Third Session of House of Delegates; scientific program featuring Obstetrics and Gynecology; special program featuring a talk by U. S. Senator Gaylord A. Nelson of Wisconsin.

Noon—Council luncheon; scientific luncheons featuring Internal Medicine, Obstetrics and Gynecology, Neurology, Dermatology, Allergy, Surgery, Office Management, and Pediatrics.

P.M.—Scientific programs featuring Obstetrics and Gynecology, Allergy, Dermatology, and Neurology; Wisconsin Society of OB–GYN business meeting.

Evening—President's Reception; Annual Dinner.

THURSDAY, MAY 15

A.M.—"Wet Clinic" of Wisconsin Surgical Society; Ophthalomolgy demonstrations and movies; scientific program for residents and interns, and Otolaryngology program.

Noon—Past Presidents luncheon; scientific luncheons featuring Internal Medicine, Plastic Surgery, Organ Transplantation, Anesthesia, Orthopedics, Otolaryngology and Pediatrics, and Ophthalmology.

P.M.—Scientific programs featuring Ophthalmology, Otolaryngology, Anesthesiology, Orthopedics, and Surgery; Wisconsin Surgical Society business meeting.

Evening—Wisconsin Surgical Society dinner; Wisconsin Orthopaedic Society dinner; and Milwaukee Ophthalmological Society dinner.

The Woman's Auxiliary also has its annual meeting and program running concurrently.

Doctors interested in joining the Flying Physicians Association or attending the 1969 annual meeting should write: Mr. Albert Carriere, Business Counsel, Flying Physicians Association Headquarters, 801 Green Bay Road, Lake Bluff, Ill. 60044.

Artificial Heart Conference

Current progress in the field of artificial-heart development will be reviewed at an Artificial Heart Conference June 9–13 at the Shoreham Hotel, Washington, D.C.

The Conference, sponsored by the National Heart Institute, National Institutes of Health, will be open to the scientific community and the press. The 5-day meeting will feature 100 presentations in key areas of bioengineering.

American College of Chest Physicians

The Council on Postgraduate Medical Education of the American College of Chest Physicians announces the following continuing education courses:

Sept. 11–13: MYOCARDIAL INFARCTION (sponsored by the University of Texas Southwestern Medical School of Dallas, Methodist Hospital of Dallas, and the American College of Chest Physicians). For further information contact: Fouad A. Bashour, MD, ACCP, 112 East Chestnut Street, Chicago, Ill. 60611.

Oct. 16–18: INTENSIVE MANAGEMENT OF PULMONARY DISEASE (sponsored by the American College of Chest Physicians and the University of Manitoba, Winnipeg, Canada). For further information contact: Reuben M. Cherniack, MD, ACCP (same address as above).

Oct 29–Nov. 2: AMERICAN COLLEGE OF CHEST PHYSICIANS FIRST FALL SCIENTIFIC ASSEMBLY (35th annual meeting), Chicago, Ill. For further information contact: Alfred Soffer, MD, ACCP (same address as above).

Aug. 3–7, 1970: 11TH INTERNATIONAL CONGRESS ON DISEASES OF THE CHEST (sponsored by the American College of Chest Physicians, Lausanne, Switzerland). For further information contact: Alfred Soffer, MD, ACCP (same address as above).

Oct. 25–30, 1970: AMERICAN COLLEGE OF CHEST PHYSICIANS SCIENTIFIC ASSEMBLY (36th annual meeting), Las Vegas, Nev. For further information contact: Alfred Soffer, MD, ACCP (at above address). □

Wisconsin Association on Alcoholism

The annual spring meeting of the Wisconsin Association on Alcoholism will be held May 2 at the Pfister Hotel in Milwaukee. The public is invited.

Theme of the meeting is "Alcoholism and the Family." Registration is at 9 a.m. followed by a welcoming address by Thomas J. Schuh, president of the Association.

Mr. James O. Kelly, executive director of The Medical Society of Milwaukee County will introduce the morning keynote speaker, Howard E. Mitchell, PhD, of the University of Pennsylvania. He is professor Urbanism and Human Resources and director of the Human Resource Center at the University. His subject will be "Alcoholism—A Family Disease."

The morning program will conclude with a lecture by Marianne Wolf, an instructor of the Ad-Hoc Faculty, University Extension, University of Wisconsin,

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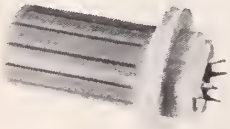

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whose subject will be "Alanon and the Family." Her introduction will be made by Mr. Frank Jacobs, counselor of the Milwaukee Council on Alcoholism.

Following lunch Dr. Darold A. Treffert, chairman of the State Medical Society of Wisconsin's Division on Alcoholism and Drug Addiction, and superintendent of Winnebago State Hospital, Winnebago, will introduce the keynote speaker, Dr. R. Gordon Bell of Canada. Doctor Bell is president of the Donwood Foundation, Toronto, Ontario, Canada, and director of The Bell Clinic of Willowdale, Ontario, Canada. His subject will be "Family Considerations in Alcoholism Treatment."

The Association's business meeting is scheduled for 2:30 that afternoon.

Registration fee: $5.50 including luncheon. Reservations should be made by April 28 to Wisconsin Association on Alcoholism, Inc., Box 329, Madison, Wis. 53701.

"OCCUPATIONAL HEALTH BOOKSHELF"

A survey of the literature in the field of occupational health has resulted in the publication of the second edition of the "Occupational Health Bookshelf," a reference list of more than 250 books selected on the basis of their value to practitioners in the broad field of health in relation to occupation.

Copies of the Bookshelf are available at 40¢ each from the Industrial Medical Association, 55 East Washington, Chicago, Ill. 60602. A publication order form listing more than 70 IMA publications and reprints is also available. □

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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Sen. Gaylord Nelson to Address Society May 14; PACE Breakfast Group to Hear Sen. Geo. Murphy

SENATOR MURPHY . . .

Sen. George L. Murphy (R-Cal.), will address a breakfast meeting of physicians Tuesday, May 13, as the three-day scientific program of the State Medical Society opens in Milwaukee.

Sen. Murphy will speak at the second annual breakfast sponsored by PACE (Professional Association for Civic Education), according to Dr. Harold J. Kief, Fond du Lac, PACE chairman. All physicians and their wives are invited.

The breakfast will be held in the East Room of the Sheraton–Schroeder hotel starting at 7:30 a.m. Reservations may be made with Dr. Kief, c/o PACE, Box 68, Waterloo, Wisconsin 53594. Tickets are available at $5.00 per person.

A native of Connecticut, Sen. Murphy studied engineering at Yale University before launching a career in acting which made him a Broadway and Hollywood star.

In 1953–54 he served as chairman of the Republican State Central Committee of California. In 1956 and 1960 he was chairman of the program for the national Republican conventions. He has served in the United States Senate since 1964.

The PACE program is presented as part of that organization's efforts to "improve government through civic education for effective political action." The State Medical Society endorsed its formation in 1963 with Dr. Gunnar Gundersen, La Crosse, its first chairman.

SENATOR NELSON . . .

Physicians attending the Society's annual meeting on Wednesday, May 14, will have an opportunity to hear Sen. Gaylord Nelson (D-Wis.) talk on the Senate drug hearings. His address is scheduled immediately following adjournment of the third session of the House of Delegates at 9:45 a.m. in the Crystal Ballroom of Hotel Sheraton–Schroeder.

Since May 1967, the Senator from Wisconsin and the Monopoly Subcommittee have been conducting an investigation into the prescription drug industry.

A former governor of Wisconsin,

continued on page 39

Sen. George Murphy

Sen. Gaylord Nelson

Legislators Actively Involved with Medical Education Bill

An omnibus medical education bill has started through the legislative halls with substantial support from the State Medical Society of Wisconsin.

Introduced by Sen. Gerald Lorge, Bear Creek, the bill (S. 283) proposes funding to:

1. Expand the University of Wisconsin Medical School to 160 students.
2. Provide support for medical education, teaching and research at the Marquette School of Medicine, Inc.
3. Create a new medical school of at least 100 students in Milwaukee, Green Bay, Marshfield or some other place selected by the University of Wisconsin Board of Regents with approval of the State building commission.

Sen. Lorge's bill would tax cigarettes and cigars to acquire the needed monies.

The three major goals of the bill were supported by the State Medical Society at a hearing March 25. The Society took no position on the fund-raising mechanism.

Strong support for the bill also came from the two medical schools. Dr. Peter Eichman, dean of the U.W. medical school in Madison, said "no one school should focus on training general practitioners—all schools should be so organized that they can make a major contribution to the expansion of family medical practitioners."

Dr. Harold Hardman, Milwaukee, associate dean of Marquette, echoed the same sentiments with regard to the training of family practitioners. He pointed out that only 18% of the 1955–65 graduates of the state's two medical schools who stayed in Wisconsin went into general medicine.

He believes this was influenced greatly by the curriculum offerings at each school. Both Wisconsin and Marquette are now moving to place more emphasis in this area.

Dr. William Russell, Sun Prairie, chairman of the State Medical Society's Commission on Public Policy, emphasized the urgency of more adequate support for the state's two medical schools, as did Dr. Russell Lewis, Marshfield, a member of the Governor's Task Force on Medical Education. The task force recommendations are largely embodied in Sen. Lorge's bill.

The proposed taxes of three cents per pack of cigarettes and two cents per cigar would raise an estimated 31 million dollars in each biennium.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others.

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EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

CESF Starts Plans for Erastus Wolcott Historical Marker

Steps to honor Erastus B. Wolcott, M.D., 1804–1880, with an official historical marker have been started by the State Medical Society's Charitable, Educational and Scientific Foundation.

Dr. Wolcott, an assistant surgeon of the Army and a surgeon general of Wisconsin, was one of the founders of the State Medical Society of Wisconsin and The Medical Society of Milwaukee County. He was one of only two surgeon generals who served throughout the entire Civil War. His enviable Civil War record was recognized when the Grand Army Post in Milwaukee was named in his honor. He was the originator of the idea to establish a Soldier's Home in Milwaukee, laying the foundation of the institution. An outstanding surgeon, his most celebrated operation was the removal of a kidney in 1861, the first operation of nephrectomy recorded.

At the same time, during a meeting in March, the Foundation trustees received a donation of $500 to be used to encourage the writing of essays on Wisconsin medical history by students at the University of Wisconsin and Marquette medical schools. Details of the essay contest will be announced later.

Society Urges Wider Use of Health Guide

A strong appeal for more widespread use of the State Medical Society's "Occupational Health Guide" has been made by the Committee on Occupational Health.

At a recent meeting, the committee reviewed situations in industry, especially in smaller plants, where use of the guide would be highly advantageous to all parties.

At the same meeting, Dr. George Handy, Madison, assistant state health officer, urged the Society to concentrate more attention on industrial health programs for small plants.

The committee is initiating efforts to present two occupational health clinics in the state within the next year or so.

Members of the committee are Drs. J. M. Wilkie, Madison, chairman; Carl Zenz, Milwaukee; D. M. Rowe, Kohler; Louis Olsman, Kenosha; W. W. Ford, Green Bay; J. V. Flannery, Wausau; A. G. Brailey, La Crosse; D. M. Ruch, Milwaukee; O. T. Mallery, Wausau; and W. A. Nielsen, West Bend.

Society Urges Review of State's Water Testing

A newly organized committee of the State Medical Society has called for immediate investigation of what it fears may be "grossly inadequate" testing of natural swimming beaches in Wisconsin.

At its first meeting, the Society's Committee on Health and Natural Resources reviewed problems of pollution in the state's swimming waters. This included a special report of the Wisconsin Division of Health dealing with Lake Neshonec at West Salem near La Crosse.

The lake was closed last summer when evidence of animal and human waste exceeded danger levels of contamination.

The committee received reports from the Division of Health which stated, among other things, that "only 2% of the state's 8,000 swimming beaches and only 5% of the public swimming pools are being tested" by the state health agency.

Unreported, but significant, is the fact that many beaches and pools are checked by local health authorities.

Nevertheless, the committee contends that the monitoring system for swimming waters appears to be "grossly inadequate to determine important bacterial contamination, and apparently ignores other types of pollution such as nitrogen and organic phosphates which serve as culture mediums." "It is clear that such waters are one direct cause of the alarming rate of eye, ear, nose and throat diseases suffered each summer in many areas of the state," the committee declared.

"We feel that there needs to be closer cooperation and communication between the state agencies doing the water testing and the physicians who often observe other important indications of dangerous pollution," said Dr. David L. Morris, West Salem, chairman of the committee.

The committee called for a full discussion of the problem with all state and federal agencies involved to assure better detection and control measures.

Other members of the committee are Drs. S. J. Graiewski, Oshkosh; O. A. Sander, Milwaukee; M. G. Rice, Stevens Point; John Noble, Black River Falls; John B. Davis, Madison; R. J. Sneed, Ashland; G. W. Dean, Milwaukee; and L. W. Chosy, Madison.

DR. MILLER APPOINTED TO WPS COMMISSION

Dr. Owen Miller, Waukesha, has been appointed to the State Medical Society's Commission on Medical Care Plans.

The appointment was announced by Dr. E. J. Nordby, chairman of the Council.

Dr. Miller is a private practitioner in orthopedic surgery.

Dr. Kief Elected PACE Chairman

Dr. Harold J. Kief, Fond du Lac, past president of the State Medical Society, has been named chairman of the board of directors of PACE (Professional Association for Civic Education).

Dr. Kief succeeds the first PACE chairman, Dr. Gunnar Gundersen, La Crosse, who was a former president of the AMA and first chairman of the American Medical Political Action Committee (AMPAC). Dr. Gundersen continues in PACE as honorary chairman.

Other officers of PACE reelected at a March 1 board meeting are Dr. Ralph P. Sproule, Milwaukee, vice-chairman; Dr. DeLore Williams, Milwaukee, vice-chairman; Mrs. W. D. James, Oconomowoc, vice-chairman and treasurer; and Mr. Paul A. Weise, Waterloo, secretary.

PACE is sponsoring an exhibit at the Milwaukee Auditorium during the Annual Meeting of the State Medical Society. It will also host a breakfast meeting at 7:30 a.m. Tuesday, May 13, with California Senator George Murphy as the principal speaker.

WPS Enrolls 1,500 in M-PLUS 15 Plan

Nearly 1,500 persons over age 65 have purchased the Wisconsin Blue Shield (WPS) Medicare-PLUS $15,000 contract as a result of the recent "open enrollment."

Each of these new subscribers receives, in addition to his contract and identification cards, a folder entitled "How to File Medicare-PLUS $15,000 Claims."

This folder explains the "how to" aspects of submitting claims for both Medicare and the WPS coverage.

The pamphlet is designed to inform patients in such a way as to reduce inquiries to physicians' offices and assist MD office assistants whenever patients raise questions.

Copies may be obtained by writing WPS, Box 1109, Madison, Wis. 53701.

SEN. GAYLORD NELSON

continued from page 37

Sen. Nelson has been a United States Senator since January 1963. His most noted legislative accomplishments have been in conservation projects, anti-poverty programs, and automotive safety and quality standards.

State Medical Society in Action: A Capsule

PROGRAMS AND SERVICES TO THE PROFESSION

Relatively few of the State Medical Society's nearly 4,200 members have occasion to know details of the wide range of activities and services carried on by the Society in the interests of the physicians and the people of the state. This is an attempt to summarize these current major programs of the Society. It includes selected activities of the nearly 50 Councils, Commissions and Committees of the Society and the

- Interpretation of the Principles of Medical Ethics, in cooperation with the American Medical Association, to assist physicians in their professional and public relationships.

- Publication of the *Wisconsin Medical Journal,* a monthly journal including scientific articles by Wisconsin authors, a unique "Green Sheet" on current socio-economic events and trends, news of Wisconsin physicians and medical societies, and editorial comment.

- The Annual January Blue Book issue of the *Wisconsin Medical Journal,* the first of its kind in the nation, providing up-to-date medical-legal information, a directory of members, tax guidelines, legislative directory, and information on the organization and structure of the medical society.

- Assistance to individual physicians and medical staffs of hospitals in working with and applying the standards of the Joint Commission on Accreditation of Hospitals.

- Planning for improved detection and control of cancer and closer working relationships with the Wisconsin Division, American Cancer Society.

- Evaluation and consultation on grievances as between physicians or patients and physicians.

- Three-day annual scientific sessions of the Society in May providing quality postgraduate educational opportunities with nearly 75 scientific speakers and about 110 scientific and technical exhibits.

- Continuing programs to expand and improve medical education at the University of Wisconsin Medical School and the Marquette School of Medicine.

- Administration of the Medical Student Loan Fund of the Charitable, Educational and Scientific Foundation of the State Medical Society which currently aids nearly 135 students with more than $175,000 in loans.

- The life, accidental death, disability and surgical-medical-hospital-major medical insurance programs of the Society available to members.

- Advocacy of the Society's position in legislation, analysis of the more than 1,200 bills introduced into the Wisconsin legislature each session, some 200–300 of which are of interest to health, medicine or medical practice, and periodic bulletins to inform the membership.

- Preparation and interpretation of the Society's "Occupational Health Guide" to assist physicians in the establishment of sound industrial health programs in plants both large and small.

- Development of the "Code of Cooperation Between Physicians, Hospitals and the News Media" and assistance to county societies in its effective application.

- Development, in cooperation with the American Medical Association, of the National Conference on Rural Health to be held in Milwaukee April 8–9, 1970.

- Continuing updating and revision of the Medical Practice Act to expand the availability of competent and qualified practitioners of medicine for all areas of Wisconsin.

- Establishment of guidelines for effective disaster medical care to cope with natural or military catastrophe.

- Leadership through Wisconsin Blue Shield (WPS) in pioneering programs of health insurance coverage utilizing the payment of "customary, usual and reasonable" charges concept and other benefit programs which allow the physician the utmost freedom to practice without interference in medical judgment.

- Initiation of numerous projects aimed at reducing death and injury as a result of motor vehicle collisions, including a 10-point highway safety program.

- General information services of the Secretary's office.

- Physician Placement Service, available to all members of the Society, and to medical interns and residents.

- Printed guides for physicians on the personal service corporation, code of necropsy procedure, interprofessional code, hearing conservation programs for Wiscon-

Summary of Current Programs and Services

principal service functions of its headquarters at Madison. Even this is far from complete. There are, for example, many special and separate projects which engage the more than 1,400 physicians who serve in some official capacity to the organization of the State Medical Society. These physicians, and the Society's staff, are always available to confer with and assist each member of the Society.

sin industry, health careers, school vision screening program, interpretation of state law relating to fee splitting, inspection of medical records, and others.

- Liaison services between Society members and state and federal agencies on matters pertaining to laws and regulations affecting health and medical services.

- Staff assistance to the Society's 16 Specialty Sections and all Society committees.

- Continuing study of problems related to pollution and the preservation of the state's natural resources for more healthful living.

- Legal consultation on matters bearing on the profession as a whole.

- Representation of the views of the profession with voluntary health agencies, public agencies, allied professional groups, and many others.

- Field service staff to report to county societies and individual physicians and in turn report physician wishes and requests to Society headquarters.

PUBLIC SERVICE PROGRAMS AND ACTIVITIES

- Presentation of the Annual Wisconsin Work Week of Health, a week-long educational program on current medical topics for teachers, students, allied health personnel, physicians, and the general public. The 1968 Work Week attracted more than 3,400 attendees.

- Grievance service facilities for the public are made available to all who believe that services are improper or fees unreasonable.

- Public information programs including dissemination of news of State Medical Society activities, statewide airing of the "March of Medicine" on 34 radio stations, public service articles for newspapers and special publications, and films, exhibits and literature on a wide variety of health subjects.

- Collaboration with federal, state and local agencies in combatting quackery in health care.

- Presentation of "clinics" for industrial health, rural health, school health, athletics, and similar topics of current concern.

- Providing statewide leadership for the expansion of medical education facilities and programs aimed at attracting and holding more physicians to practice in Wisconsin.

- Special conferences on health care costs involving representatives of state government, health care providers and the business, labor and "consumer" community, to seek the utmost economy while assuring needed and quality health care for all.

- Efforts to protect the public health by the expansion of full-time, adequately budgeted, city-county, county or multiple-county health departments, and the development of medical examiner systems to replace the coroner system in Wisconsin.

- Joint programs with the Wisconsin Health Council to interest and attract men and women to careers in the health field. Up-to-date informative materials on all health career opportunities is provided upon request.

- Operation of the Museum of Medical Progress and the Stovall Hall of Health at Prairie du Chien as major public health education efforts of the Society's Foundation.

- Preparation and distribution of the Workmen's Compensation "Open Panels" to assist business and industry in complying with the free choice requirements of the Workmen's Compensation Act.

- Committee activities on safety, pollution, emergency care, disease detection, prevention and control, and hundreds of specific projects aimed at health education.

- Availability to the public from Wisconsin Blue Shield (WPS) of broad health insurance benefit programs for coverage of surgical-medical-hospital-major medical-drug-dental and other expense of illness and accident.

- Development and offering of the nation's first "Health Care Charge Card" through the WPS Health Care Charge Card Corporation.

Society Reports State Medicaid Expenditures

Sixty-two drug stores, seven physicians, and two physical therapists outside Milwaukee County received more than $25,000 each in Medicaid payments from Wisconsin Blue Shield (WPS) last year, according to the State Medical Society.

The report on payments to health care providers has been requested of state Medicaid programs by the U. S. Senate Finance Committee under the chairmanship of Senator Long (D–La.). The committee is reportedly scheduling hearings for mid-April on ways to curb Medicaid expenditures.

A total of $18,758,000 was paid to all Medicaid health care providers in the state outside Milwaukee County, according to the Medical Society. Figures were provided from the records of Wisconsin Blue Shield (WPS), a Medical Society division which serves as contractor for the Medicaid program in all counties except Milwaukee.

Medicaid payments in Milwaukee County are handled through Surgical Care Blue Shield of The Medical Society of Milwaukee County.

Report Could Be Misleading

The Wisconsin Department of Health and Social Services states that Surgical Care (Blue Shield) of Milwaukee County has reported 21 providers as receiving over $25,000 in 1968 for Medicaid services. This included 12 identified either as individual physicians or medical groups; five dentists; one chiropodist; one optometrist; one physical therapy group; and one dialysis group. To date Surgical Care has not reported druggists in this category.

No hospital payments were reported since these are handled by Associated Hospital Service (Blue Cross) for the entire state.

Medicaid payments made in 1968 by Wisconsin Blue Shield were spread among nearly 3,000 physicians, 1,500 dentists, 1,200 pharmacists and 2,800 other providers such as ambulance drivers, physical therapists, podiatrists, and medical supply firms.

"Although we have been requested to provide only the names of the providers and the amounts of payments, we refuse to limit our report in this way because such information, by itself, would be absurdly inaccurate and misleading," according to Dr. W. D. James, Oconomowoc, president of the State Medical Society.

"For example, several of the pharmacies on the list are multiple-location drug stores, one of which has 20 outlets," Dr. James reported.

Providers Explained

Of the seven physicians listed by Wisconsin Blue Shield as receiving over $25,000, one was a psychiatrist who signed Medicaid forms for himself and six other psychiatrists in his group as a matter of "administrative efficiency;" another was a psychiatrist with a large referred practice from courts and welfare departments; two were general practitioners in rural areas where a high percentage of patients are on some type of public assistance; two were specialists in charge of renal dialysis units, and one practiced general medicine and surgery in a metropolitan area where about "75% of my patients" are on some kind of public aid.

"The medical profession can be justly proud of its role in providing this care. We pledge our continued efforts to provide the highest quality care at the most reasonable cost consistent with the services required," Dr. James said.

Dr. James observed that, "patients who are forced by circumstance of health or economics to accept public assistance through Medicaid are getting more and better health care than ever before."

Among the payments made by Wisconsin Blue Shield to physicians were those to doctors who provide services in low income areas from two offices as many as 20 miles apart. In these situations, 50–75 percent of the physicians' patients are reported to be on some type of public assistance.

Dr. James said that in other cases, the Medicaid payments represented the physicians' charges plus those of several nurses and technicians whose services were required for the operation of kidney dialysis units. Such treatments are required to maintain life while patients with kidney disease await transplant donors.

"Medicaid is a growing headache to patients, doctors, and the agencies responsible for its administration," according to Dr. James.

"The federal and state planners of Medicaid chose to ignore a quarter century of experience by private health insurance plans in developing simple and efficient administrative procedures, including reasonably uniform claim forms.

"As a result, Medicaid is a paper monster for everyone, eating up time that doctors ought better give to patients, gobbling up clerical help and leaving a chaos of confusion which irritates patients, pushes office expenses higher and higher and creates unnecessarily expensive costs for the administering agencies," Dr. James said.

Medicaid Expenditures

The Wisconsin Department of Health and Social Services, which directs the state Medicaid program, reports a total expenditure of $115,000,000 for health services to beneficiaries between July 1967 and June 1968. Nearly 41 percent of this (about $47,000,000) was for nursing home care; 13 percent ($15,000,000) for hospital care; eight percent ($9,000,000) for physicians' services; about six percent ($7,300,000) for drugs; and the remainder went for care in the colonies for the retarded and other services.

Wisconsin Legislative Round-Up

CHIROPRACTIC . . . Bill 97, A. would require payment for chiropractic services under Medicaid (Title 19). The Assembly Committee on Public Welfare has recommended this bill for PASSAGE. The State Medical Society is OPPOSED. Recent HEW study of chiro services under Medicaid concluded that regardless of their theory, chiros have neither the training nor ability to adequately diagnose or treat the sick. URGENT you contact your Assemblyman.

MEDICAL EDUCATION . . . Bill 283, S. would provide financial assistance for U.W. medical school to expand to 160 students; help expand Marquette medical school's teaching programs and meet its fiscal crisis; and launch plans for a third medical school in the state. SMS SUPPORTS in principle, since it embodies the most important priorities for expanding medical education in Wisconsin.

MEASLES . . . Bill 120, S. would permit the State Division of Health to conduct voluntary measles immunization programs. SMS SUPPORTS voluntary as opposed to compulsory programs.

ANATOMICAL GIFT ACT . . . Bill 4, A. has passed the Assembly with an amendment which would permit parents of minor children to revoke the gift of the body or any part thereof. SMS SUPPORTS THE ORIGINAL BILL WITHOUT AMENDMENT.

SAFETY GLASSES . . . Bill 251, S. would require students in such classes as chemistry and industrial arts to wear safety glasses. SMS SUPPORTS . . . the bill was introduced at the request of the Wisconsin Society for the Prevention of Blindness and with support from the Society's Section on Ophthalmology.

MORE CHIROPRACTIC . . . Bill 307, A. would require payment of chiropractic services under the Workmen's Compensation laws. SMS OPPOSES.

MEDICAL REVIEW IN DRIVER LICENSING . . . Bill 318, A. would create a medical council under the Wisconsin Department of Transportation. This expands the long-standing operation of an epilepsy review board into one which would deal with all medical impairment as related to driver licensing. SMS SUPPORTS.

PSYCHOLOGY LICENSING . . . Bill 20, A. would require the licensing of any PhD who holds himself out as practicing psychology. The bill has been referred to the Legislature's Joint Finance Committee, but the Assembly Public Welfare Committee has already recommended its PASSAGE. SMS OPPOSES. It is the position of the Council of the Society that psychotherapy is the

continued on page 44

 continued from page 43

practice of medicine; that if psychologists do not wish to practice under the general supervision of a physician, they should take the basic science examinations as must other limited licensees who treat the sick. The bill does not prohibit the prescribing of drugs, nor the use of surgery. It does not provide adequate funds for enforcement of the act. SMS OPPOSES, but is awaiting response from psychologists on invitation to joint drafting of legislation agreeable to all.

SLOW MOVING VEHICLES . . . Bill 16, A. requires vehicles designed for use at less than 25 miles per hour (except bicycles) to display SMV sign. SMS SUPPORTS.

MD REGISTRATION FEES . . . Bill 95, S. would authorize the State's general fund to take over any registration fees "left over" at year end from operations of the Medical Examining Board. Under the bill, the Board would lose control of its own employes who deal with confidential information and physician licensure matters. SMS OPPOSES.

OPTICIANS . . . Bill 390, S. would certify opticians through an examining committee of the Medical Examining Board.

MENTAL HEALTH ACT REVISIONS . . . Bill 61, S. rewrites and updates the state mental health act adopted first in 1951. SMS SUPPORTS the bill in principle, including amendments proposed by the Wisconsin Board of Health and Social Services which would eliminate portions of the bill allowing "clinical psychologists" to augment or partially replace physician examinations in involuntary commitments.

AMBULANCE ATTENDANTS . . . Bill 217, S. proposes standards of training and other qualifications for persons involved in transportation of the ill and injured. SMS SUPPORTS.

SEAT BELTS . . . Bill 214, S. provides for mandatory use of seat belts in autos. SMS OPPOSES the mandatory feature but favors educational efforts to encourage use of belts.

IMPLIED CONSENT . . . Bills 219, S. and 355, A. propose adoption of implied consent legislation to aid in the control and deterrence of the drinking-driving problem. SMS SUPPORTS in principle.

LICENSING HEARING AID DEALERS . . . Bill 391, A. proposes to license dealers in hearing aids, and requires that any person under 16 seeking to purchase a hearing aid must present the dealer with evidence of examination by a physician and a recommendation for an aid. SMS OPPOSED the bill at hearing stating that such dealers should be examined through a committee of the Medical Examining Board or other appropriate existing department rather than creating still another separate licensing agency.

MINOR BLOOD DONORS . . . Bill 295, S. would allow minors 18 or over to donate blood without parental consent.

trends
The Wisconsin Regional Medical Program, Inc.

APRIL, 1969

WRMP RECEIVES $302,500 GRANT FROM DRMP; AWARD ONE-THIRD OF ORIGINAL REQUEST

Several Programs Delayed Because Of Restricted Federal Spending

The Wisconsin Regional Medical Program, Inc. (WRMP), Milwaukee, was awarded a three-year supplementary grant of $302,500 by the Division of Regional Medical Programs of the Department of Health, Education, and Welfare, Washington, D. C.

The announcement was made by Dr. John S. Hirschboeck, program coordinator.

Hirschboeck announced that the grant consisted of a $83,250 award for cancer chemotherapy for Metropolitan Milwaukee, $78,250 for the tissue typing program, $57,750 for uterine cytology screening, $45,150 earmarked for postgraduate education, and $38,100 for nursing care programs of WRMP.

In addition, $25,850 was awarded postgraduate education from basic operating funds and $2,900 was awarded the uterine cytology program.

Only one-third of the requested money was received through the grant because of restrictions in federal spending.

All of the projects funded come under the goals of WRMP which are to coordinate the activities of hospitals, medical schools, physicians, nurses and other medical organizations throughout the Wisconsin area so speedier and more efficient service can be accomplished in combating heart disease, stroke, cancer and other related diseases.

Dr. Hirschboeck

Duckworth

"Although we received only one-third of our initial request, I feel we can make some headway in these areas where we have received funds," Hirschboeck said. "I am confident that the Division of Regional Medical Programs will examine very carefully our programs within the next few months and take note of the headway we have made."

T. A. Duckworth, WRMP president and senior vice-president and secretary, Employers Insurance of Wausau, Wausau, Wis., said that the various committees in the planning area will have to take a good hard look at the areas which have been deferred until a later date.

"This does not only mean the WRMP staff but the volunteer physicians, lawyers and other professional people working on these committees," he said. "It isn't going to be an easy job. It will require a great deal of thought and planning to make a decision as to what direction we will take concerning future applications for funds for new projects.

"As for the funded projects," Duckworth added, "I am confident the project directors will utilize these funds as effectively as possible in order to bring about a more efficient health care and service program to the patient."

The Wisconsin Regional Medical Program, Inc., established two years ago, has achieved satisfactory results in several operational programs related to the areas of heart disease, stroke and cancer. The program was the fifth in the country to become operational. Presently, there are 55 such programs established throughout the country.

TRENDS is a new quarterly publication of The Wisconsin Regional Medical Program, Inc. (WRMP), Milwaukee. Its purpose is to give everyone, directly and indirectly associated with the medical field, an insight as to what WRMP is and what it is doing to help improve patient care in the areas of heart, stroke, cancer and other related diseases.

"DIAL ACCESS" READY TO ANSWER QUESTIONS OF WISCONSIN PHYSICIANS AND NURSES

Both Programs Used In Various Ways To Meet Personal Needs

Case History

Patient — Michael, age 30 hours.

Symptoms — Blue and breathing with great difficulty and having spells of not breathing at all at times because of exhaustion.

Treatment — Moist oxygen, but this doesn't seem to be enough!

The physician placed a call to The Wisconsin Regional Medical Program, Inc. (WRMP) "Dial Access Library" and asked for tape number 42 — "Respiratory Distress in Newborn, Diagnosis and Management," by Stanley N. Graven, M.D., Madison. During the next five minutes, the physician listened to a tape recording giving the current information available on the topic.

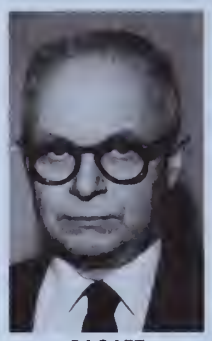
This was an actual case presented to Dial Access. It no doubt was a time saving device both for the doctor and for the patient.

"This service is of great value and should be continued," one physician said, "In fact it should be expanded. It saves much time as it eliminates the need of researching journals to find out the latest advances. Time is too precious to me, and to the patient."

This opinion sums up the attitude of the physician to a novel form of medical information bank available to all physicians in the Wisconsin area, on a 24-hour basis, with no charge involved.

WRMP's "Dial Access Library" is in its third year of operation, but in its first year of offering free service through support of WRMP. Subject matter has increased from 88 to almost 300 topics covering a variety of subjects from *Blood and Lymphatics* to *Psychiatry*.

The original idea was developed by Thomas C. Meyer, M.D., assistant dean of postgraduate education at the University of Wisconsin Medical School.



RAGATZ

DR. MEYER

"We are very satisfied with the program," Dr. Meyer said. "It has not been promoted as much as would have liked because of the lack of finances. Recently, we have had nationwide attention. Other regional medical programs want to duplicate our library for their own use. This makes me believe that the importance of this program is unmeasurable. This type of service is needed in the medical field because time is becoming ever more important to the physician and to the patient."

Roy T. Ragatz, coordinator of the Dial Access system, said that more than 1,200 calls were registered during the first year of operation when it was on a toll charge basis. Almost 7,000 calls have been placed in 1968 when the service was made available without charge.

"Most of these calls were placed by general practioners," Ragatz said. "Approximately 1,800 calls were made by specialists and another 1,800 by students and interns. It is anticipated that, with the addition of new tapes, more than 8,000 calls will be placed to the library in 1969."

Dr. Josef Enzinger, a general practitioner at Park Falls, Wisconsin, has been an avid user of Dial Access since 1966.

"It is an asset to the physician in the country," Dr. Enzinger said. "Very seldom am I able to attend conferences or lectures regarding new techniques or methods used in medicine today. Consequently, Dial Access is one way for me to keep abreast of the advances in the field."

Park Falls, with a population of 3,000 people, has four physicians.

"There really isn't too much time available to any of us," Dr. Enzinger continued. "Once in awhile, I find time to make a call during the day. Most of the time, however, I call about midnight when things are a little slow and I am able to catch a little rest.

"I feel the most convenient thing about the program is its 24-hour availability," he continued. "Too many of us have too little time during the day because of the patient load."

Since September, 1968, a "Nurses Dial Access" program has been in operation to complement the service available to doctors. The library is a combination of tapes prepared exclusively for nurses. Physician tapes which contain information helpful to nurses as well as physicians are also used.

St. Mary's Hospital, Milwaukee, has incorporated the "Nurses Dial Access" program into their educational program.

Sr. Lucille, director of the department of nursing, said the program has been used to a great degree to help train student nurses and to help bring back "inactive" nurses.

"Our primary purpose for the utilization of the Dial Access was to help in the educational process of student nurses," she said. "Cer-

DR. ENZINGER — ". . . one way for me to keep abreast of the advances . . ."

DIAL ACCESS — Aids student nurses as well as the "inactive" nurse.

tain topics are scheduled for discussion. The students then, in the evening, call Dial Access and listen to a particular topic. The next day the topic is discussed in the classroom. We find this very beneficial. The students seem to grasp the material more readily."

A by-product of the program at St. Mary's was recognized when it was found that "inactive" nurses also became interested in "learning by telephone."

"Because of the great amount of interest they have shown we have begun making the dial access program known through our alumnae publications and meetings," she explained. "There has been a great response so far."

The Dial Access program can be applied in a number of ways to meet the requirements of a number of different situations, Ragatz added. It's a matter of who wants to use it and how they want to apply the program.

SE Wisconsin Cancer Conference Scheduled April 12

The First Annual Southeastern Wisconsin Cancer Conference was held on April 12 in Milwaukee at the Holiday Inn Central.

The Conference, under the chairmanship of Joseph Gramling, M.D., highlighted several nationally known speakers in the field of breast cancer.

WRMP . . .
A LOOK INTO THE FUTURE

By
JOHN S. HIRSCHBOECK, M.D.
Program Coordinator

How will Regional Medical Programs fare under the Nixon administration? Will Congress slow down its support of the programs? Will the programs undergo significant modification as a result of the reorganization of the Department of Health, Education, and Welfare?

If what we see and hear in the news media is an indication, matters other than health and medical research dominate the public concern. The Vietnam War, problems of the cities, poverty, the crisis in education, civil rights, transportation, and the conservation of national resources occupy the stage which a few years ago was dominated by medical research, the space program, and the improvement of hospital facilities.

Senator Lister Hill and Congressman John Fogerty are no longer available to rally support for appropriations which often exceeded the recommendations in the President's budget. Leadership in the Department of HEW has also changed with the retirement of Dr. Phillip Lee and Dr. James Shannon. Medicare and Medicade have turned out to be much more expensive than anticipated, and these programs are crowding the budget, so that it may become more difficult to obtain the funds needed for the other health programs.

In its report to Congress recommending the continuation of Regional Medical Programs, the Surgeon General's Commission recommended that if Regional Medical Programs were to do the job cut out for them, they would require between $450,000,000 and $500,000,000 a year in Federal appropriations. The President's recommended appropriation for the 1970 fiscal year is $120,000,000. There is a danger that Congress may set this as the maximum level for subsequent years. Such a decision will, of course, be a serious blow to the Regional Medical Programs. The programs will accomplish very little for the American public unless they have sufficient support to improve the delivery of the advances in medical science and health care to the people.

There is, however, a growing expressed feeling that Regional Medical Programs are right on target as programs of the future and, as such, should gain the attention and support of the new administration since they are not only non-partisan, but . . .

President Nixon has repeatedly called for greater emphasis on coupling Federal programs with local initiative to solve local problems.

In his Inaugural Address he touched upon this concept several times.

"— Our greatest need now is to reach beyond government, to enlist the legions of the concerned and the committed," he said. "What has to be done, has to be done by government and people together or it will not be done at all . . . we need the energies of our people — enlisted not only in grant enterprises, but . . . in those small, splended efforts that make headlines in the neighborhood newspaper instead of the national journal."

Regional Medical Programs are local, and are working on local health problems with Federal support. Therefore, Regional Medical Programs could become the health models of what Mr. Nixon is calling for in all areas of activity.

Secretary Finch of the Department of Health, Education, and Welfare has been quoted as saying he wants to continue to support and encourage those on-going programs with the greatest potential rather than perpetuating ineffective ones or starting new ones.

Regional Medical Programs as on-going activities are demonstrating their potential and, therefore, would appear to merit a place at the top of the list of health programs to be supported and encouraged in 1970 and thereafter.

REGIONAL ADVISORY COMMITTEE GOAL TO FURTHER OBJECTIVES OF WRMP

By
JUDGE RODNEY LEE YOUNG

Actively participating in the WRMP project planning program from the initial steps onward through review and recommendation, is the goal of the Regional Advisory Committee.

Recognizing that the WRMP, after two years of existence has passed the growing and organizational pains, the membership of the Advisory Committee seeks to actively participate in the progress of project applications through the study groups and Planning Committee so that it may more effectively offer guidance and suggestions to those who are directly responsible for the planning.

Responding to the comment of the Division of Regional Medical Programs recently, the Regional Advisory Committee, at a recent meeting, made numerous recommendations to establish closer liason with the study groups and the Planning Committee.

Working on the proposals is an ad hoc committee appointed by me.

The committee consists of:

David A. Herman, Partner, Barkin-Herman and Associates; Russell F. Lewis, M.D., President, Marshfield Clinic; L. J. Van Hecke, M.D., President, Milwaukee Division, The American Cancer Society, Inc.; Gerald Nadler, Ph.D., Professor of Industrial Engineering, University of Wisconsin; Robert E. Callan, M.D., President-Elect, The State Medical Society of Wisconsin; Peter J. Sheldon, Department of Sociology, Marquette University, and Division of Preventive Medicine, Marquette School of Medicine; Warren R. Von Ehren, Executive Director, Wisconsin Hospital Association; John S. Hirschboeck, M.D., WRMP Program Coordinator; Paul C. Nutt, WRMP Planning Coordinator; James H. Sullivan, WRMP Assistant Program Coordinator and myself as Chairman.

The Regional Advisory Committee of WRMP seeks to further the objectives of the Regional Medical Programs and to assure that the "substantial medical care to be delivered at the local level will reflect the advances being made in the research laboratories, hospitals and clinics;" to stimulate and initiate projects to the end that we might bridge the gap of medical science and medical service on the community level.

Trends is published quarterly by The Wisconsin Regional Medical Program, Inc., 110 E. Wisconsin Ave., Milwaukee, Wis. 53202. Articles for publication can be sent to the above address in care of Director, Public Information.

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Workshop on Health Planning Scheduled for May 19-23

"Workshop Toward More Effective Health Planning" is the title of a five day program to be held at the University of Wisconsin-Madison under the co-sponsorship of the Division of Regional Medical Programs and The Wisconsin Regional Medical Program, Inc.

The program, to be held May 19-23, will be geared to those who are interested in improving their organization's health planning through practical methods and application.

Dr. David H. Gustafson, program chairman, said the course will concentrate on understanding and applying (in case settings) practical procedures, types and organizational concepts for systematic health planning. The Workshop will cover the practical methods for identifying problems, developing solutions to these problems, implementing these solutions and evaluation.

There will be no fee charged for the course. There will, however, be a slight charge for room and board. Enrollment will be limited to 40 applicants with selection made on the basis of current involvement and interest in health planning on the part of the applicant. For an application write: William W. Wuerger, University of Wisconsin-Extension Division, 432 N. Lake St., Madison, Wis. 53706.

W. D. James, M.D.

PRESIDENT'S PAGE

The Dilemma of Computer Medicine

AT THE RECENT National Congress on the Socio-Economics of Health Care, one of the speakers advocated using computer programing in taking medical histories and in arriving at diagnoses, a process which would provide simultaneously a permanent record of the patient's history and treatment.

He cited as advantages of this technique the time saved by the physician and the greater accuracy of a history taken from a standard programed list of questions. A further advantage would be the availability of the patient's history and a record of his treatment to any physician who might subsequently treat him.

While computer medicine has some obvious advantages in both speed and accuracy, some equally obvious questions arise as to its practicability. Computers are expensive and would be feasible only where they are readily available to large groups of physicians and patients. Since they are only as accurate as the humans who program them, there would be need for a large number of very highly skilled technicians. How soon would they be available in numbers large enough to make mechanical medicine available to any great share of the population?

Another question that must persist in the minds of physicians and patients alike is this: Would even a "medical machine" make some of the silly mistakes that are made daily by those in use in schools, businesses, and airline offices?

Would too great a reliance on computer diagnosis impair the medical judgment of those physicians who might suddenly find themselves without its services?

Because the growth of medical knowledge and of the population is placing ever-increasing demands on the time and the skills of the physician, it is essential that we avail ourselves of every technical advance to help us bring better medicine to more people. However, let us beware of the delusion that a computer can replace a competent, conscientious physician who daily must deal with the whole gamut of human distress.

To quote the quite elderly patient of an elderly physician: "I don't know what I will do if my doctor ever retires. When he comes to see me, he takes my pulse and listens to all my complaints. Then he gives me some kind advice—and I feel so much better. What more can you expect at my age?"

Can the impersonal analysis of a mechanized brain be equated with the sympathetic, human understanding of a personal physician?

W. D. James M.D.

the WISCONSIN MEDICAL JOURNAL
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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

They Deserve Better

■ IN RECENT YEARS the establishment and operation of nursing homes for the aged seems to have become a very profitable industry. The publicly held stock of more than one such enterprise showed a spectacular rise in price on the stock market a few months ago, and reports of the huge profits to be made by providing havens for the elderly are rife.

While nursing homes are undoubtedly interesting investments for those looking for growth and income opportunities, they are viewed less enthusiastically by those oldsters who find themselves resident in them. To the aged, a nursing home is often the carpet under which he is swept when he is of no further use to the family he raised. To his children, on whom time and the aging process have made him dependent, the nursing home is a place where they can dispose of the disagreeable burden without losing community respect.

Unfortunately, many physicians share the public's misconceptions and stereotypes about the aged. This fact was demonstrated by a recent study at the University of California Medical Center in San Francisco, reported in the *Journal of the American Geriatric Society*. Questionnaires were submitted to entering freshmen medical students and to senior medical students. Analysis of the answers showed little influence of medical education on attitudes found in the tyro physicians. Most of them regarded aged persons as disagreeable, inactive, economically burdensome, dependent, dull, socially undesirable, dissatisfied, withdrawn and disruptive in the family. They felt the geriatric patient had more political influence than he deserved, that he was unwilling to work and that he was not as anxious about the future as he should be. Worse yet, almost all revealed a strong prejudice against the aged in their responses to a series of hypothetical questions about medical situations involving treatment choices of young versus old. There was unanimity in placing wards for the chronically ill aged patient last as an area of preferred medical service. They felt that a doctor who was a brilliant therapist should be assigned to a general medical ward whereas a physician who was not too clever, but rather kindly and good-natured, was the best type for a geriatric assignment.

While it is true that in 1970 more than half of the population of the United States will be in their early twenties or less, the number of candidates for geriatric care facilities will also have increased tremendously. The attitudes of physicians treating the aged will have to change. A project to bring about that change was started in 1955 when the American Medical Association first established a Committee on Aging. The scope of the committee was originally medical, but it has since expanded to cover the

social, psychological, and environmental aspects of geriatrics, with special emphasis on the attainment of the best possible health care and restoration for those who are ill. The State Medical Society of Wisconsin has established a "Division on Aging" to augment the activity of the AMA committee. Both bodies subscribe to a multiphasic approach to geriatric care, but perhaps the most significant gospel preached by these agencies is that there are no diseases peculiar to the aged.

It is bad enough for the ailing aged person to gain the impression that he is cut off from life by relegation to a nursing home. It is even worse if his physician underscores that impression by treating him in a perfunctory or condescending manner, when visits become rare and hurried, and it becomes obvious that the treatment plan is not designed to alter the inexorable march to the tomb.

Every physician treating the aged owes it to his patients to take a fresh look at his own attitudes. The elderly are still members of the human race, each one made in the image of God, as we are told, and worthy of the best efforts of his doctor. The doctor may be the last and only friend the senior citizen has, and respect for his humanity, if not for his contribution to society, demands that he be given the attention every other human being receives.—D.N.G.

Coronary Arteriography

ANGINA PECTORIS, one of the oldest terms in medicine, has long been equated with myocardial hypoxia, and associated with either actual infarction or the threat thereof.

For the most part, the diagnosis can be made with certainty on the basis of the clinical picture and the electrocardiographic studies. But there have always been the few situations in which the precise diagnosis remained in doubt.

Because coronary arteriography has provided us with an important new insight into this area, the editors are pleased to publish the excellent paper of Rowe and Young in this edition of the *Wisconsin Medical Journal.*

At the present writing, it appears that the clearest indications are found in the young individual with a classical anginal syndrome, but lacking in the electrocardiographic evidence of myocardial hypoxia. In such a situation, angiography may very well provide the answer by indicating the presence or absence of coronary insufficiency, as well as the degree thereof, and perhaps even the type.

However, as knowledge accumulated from the use of this technique, another very interesting facet of coronary artery disease was discovered. Neill, Kassebaum, and Judkins (*New England J. Med.* 279:789 [Oct 10] 1968) described a case in which a 48-year-old woman presented the classical symptoms of the anginal syndrome, including the accepted criteria of ECG changes with exercise, but with a normal coronary angiogram.

The immediate effect of this observation was to broaden the indications for the use of coronary arteriography. In short, it may be applicable even in those cases where the older standards of diagnosis have been accepted with complete confidence.

We are thus in the process of reshaping our concept of coronary artery disease as well as our concept of angina pectoris.

It is important for practitioners to know that coronary arteriography is available. But it is even more important for practitioners to exercise their seasoned clinical judgment in selecting the cases for examination, a judgment that must rest on the basis of possible benefit to the patient.—LESLIE G. KINDSCHI, MD, Monroe

Plan Ahead

THAT REFRESHING summer event—the Annual Convention of the American Medical Association—comes slightly later than usual this year. But once again the "AMA Annual" should figure significantly in advance planning of physicians.

The Annual Convention of course is the largest of the many meetings sponsored annually by the AMA. It covers so much of professional interest, and attracts so many physicians, members of allied health professions, industrial exhibitors, and guests, that only a relatively few cities have ample facilities to accommodate it.

This year's Annual Convention will be in the nation's largest city. Because the dates are July 13 through 17, it might be well to add that New York also ranks prominently in extent of air conditioning. But the Empire State's weather can be pleasant in July, and New York City also can benefit from any cool ocean breezes.

For the many physicians who take their families to the AMA Annual Convention, the New York City area obviously offers many and varied attractions.

There is no question about the benefits for the physician. Among other things, there is opportunity to ask questions, discuss techniques and developments with experts, and enter into dialogue

which no other means of medical communication allows so extensively and instantaneously.

Four general scientific meetings are offered, as well as 23 section programs (with the Section on Special Topics offering six sessions), breakfast roundtables and fireside conferences.

Additional postgraduate education is available through the exhibits, medical motion pictures and scientific television presentations.

This might be an excellent time—not a moment too soon—to put down those dates (July 13 through 17) on your calendar, talk to the family about going to New York together, and start planning reservations and other details. The American Medical Association's 118th Annual Convention will be here before you know it! □

LETTERS

MULTIPLE SCLEROSIS PUBLICATIONS

To the EDITOR:

The Multiple Sclerosis Society has the below-listed publications for multiple sclerosis patients. However, they can be made available only upon written request of a physician. Physicians are advised that if a MS patient fits into the category described by the title of the brochure, to advise the patient that he may obtain the publication from the Multiple Sclerosis Society with a written request made by him (physician). In Madison, the publications will be supplied by the Central Wisconsin Chapter (address below). The patient should contact his local multiple sclerosis chapter first.

The publications are:

A Home Program for Independently Ambulatory Patients
A Home Program for Patients Ambulatory with Aids
A Home Program for Wheel Chair Patients
A Home Program for the Care of Bed Patients
Mental Health and MS by Molly Marrower, PhD

MRS. PHYLLIS B. GOLDSTEIN
Executive Director
Central Wisconsin Chapter
National Multiple Sclerosis Society
P. O. Box 2152
Madison, Wisconsin 53701
(Tel. 257–5544)

"CANCER FAMILY SYNDROME" PATIENTS

To the EDITOR:

The Medical Genetics Section of the Department of Preventive Medicine and Public Health at Creighton University School of Medicine, Omaha, Nebraska, is interested in the study of patients showing an increased incidence of any histological variety of cancer in their families. Of particular interest to us is the cancer family syndrome, characterized by: 1) increased frequency of adenocarcinoma of all sites, particularly of the colon and endometrium, 2) early age at onset of cancer, 3) increased occurrences of multiple primary malignant neoplasms, and 4) autosomal dominant inheritance. To date, we have investigated six families fulfilling all of the above criteria (Lynch, H. T., and Krush, A. J.: Heredity and Adenocarcinoma of the Colon, **Gastroenterology 53**:517–527, 1967), and have corresponded with physicians in Europe who have described two separate and nonrelated families which also fulfill the above criteria.

Physicians with patients known to have a familial cancer background, may write to Henry T. Lynch, MD, Associate Professor and Chairman, Department of Preventive Medicine and Public Health, Creighton University School of Medicine, 657 North 27th Street, Omaha, Nebraska 68131.

We invite your cooperation in our studies which will include a genealogical and medical investigation of the entire kindred in each case. All information obtained will be shared with family physicians in order to facilitate cancer control.

HENRY T. LYNCH, MD
Omaha, Nebraska 68131

WANTED: THYMECTOMY PATIENTS

To the EDITOR:

I am interested in studying the effects of thymectomy in an adult population. There are undoubtedly many patients in the State of Wisconsin who have had thymectomy performed for myasthenia gravis or malignant or benign thymomas. If at all possible, I would like to obtain the names of such patients through the physicians of the State of Wisconsin in order to ask these people if they would participate in an experiment. The experiment would call for only the contribution of 40 cc. of blood by these patients.

Any information that I could receive regarding this particular type of patient would be greatly appreciated.

WILLIAM A. KISKEN, MD
Associate Professor of Surgery
University Hospitals
1300 University Avenue
Madison, Wisconsin 53706
(Tel. area code 608/262–3146 or 262–7776)

HAPPY WITH MOVE TO WISCONSIN

To SMS:

I am most thankful for the wonderful opportunity offered to me in this beautiful north country of Wisconsin. All my life I've dreamed of a place such as this. It has been a dream world from the first instant I settled in Hayward.

It constantly amazes me—the difference in life and living between the hectic, frenzied, rat-race in the Chicago suburb I left and the serene, tranquil atmosphere I found here.

RUDOLPH D'ELIA, MD
Route 1 Box 54
Hayward, Wisconsin

□

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis, with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

APRIL 1969

THE DECLINING NUMBER of primary physicians in Wisconsin in the face of an increasing total number of physicians has been well documented at the recent State Medical Society "Conference on Proposals to Ease the Physician Shortage in Wisconsin." Further, a concentration of physicians in medical education centers, and accompanying depletion of physicians in smaller communities and "core" areas, may be noted. Many of the causes may be found in the present medical education system in the state.

The present production of physicians in the state is insufficient to maintain the present patient/physician ratio in the face of increasing population. Not only the financial woes of Marquette School of Medicine but also the small projected output of the new University of Wisconsin Medical Center should be considered in planning the state's future physician production.

Since not only the rural areas but also the urban cores are faced with a physician shortage, we should question whether the present percentage of Negro students in the state's medical schools (0.25%) is adequate to meet the needs of the state's Negro citizens (2.5% of the population).

SCHOOL CURRICULAE NEEDS CHANGE

Part of the problem involves present medical school curriculae. I can speak only of Madison's. Since University Hospitals is a referral institution and our teaching staff is also a research staff, we, all too frequently, learn introductions to the specialties instead of a general grounding in medicine. The assumption that men in the forefront of their specialty are necessarily the best teachers is frequently not borne out. The type of teaching we get directs our interests away from primary care practice and often leaves us unprepared for it.

Not the least in directing us toward city specialty practice, is the impression, warranted or not, that we gain of small group or solo practitioners. The patients we see are frequently the local practitioner's mistakes. We gain an impression that once one enters such a practice, his continuing medical education ends. This impression is assisted by the resistance that we see to improved certification procedures for family practitioners. It seems that the immediate demands of such a practice are too imperative to allow time for continuing education or recreation.

STATE'S DOCTORS CAN HELP

Despite the above comments, I firmly believe that the state's practitioners have the potential of greatly assisting our medical education. I feel that the medical school should be indicted for making poor use of the abundant resources of clinical material and instruction that the state's physicians can provide. Our preceptorships are an excellent start, but they are too little and too late. By sending us out earlier to the state's clinics, the inadequacies in our education in primary patient care could be to a large extent alleviated. The barriers of inadequate clinical material and staff which presently limit medical school enrollment expansion would also be decreased. As a selling point for practice in the state, we would then see the family practitioner's successes instead of just his limitations.

Many of us are disturbed by the inequities of the medical system today and hope for planning and financing of medical care directed to the needs of *all* patients in the state. Much of the present inadequate medical care could be improved by a reasoned distribution and coordination of medical services.

Much of what I have said above is speculative and long-range. I would like to mention one thing that the state's physicians can do now to show us why "MDs Like It Here." Under the UW Medical School's new curriculum, students have free summers after their first and third years of medical school and possible elective time in their fourth year. There was much demand by students in my class for externships last summer. I feel that the state's practitioners are missing a chance to "win us over," fill gaps in our medical education, and correct our ideas about their medical practice by not providing more of such externships. I suggest that those practitioners who would be interested in taking a medical student for a training period, contact such groups as the Student Health Organization, Student American Medical Association, Wisconsin Academy of General Practice, or the State Medical Society of Wisconsin.

We would like to be convinced of the quality and desirability of medical practice in Wisconsin.
—KENNETH FELDMAN, Med. III, University of Wisconsin. □

SECTION OPHTHALMOLOGY

APRIL 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

NATIONAL CONFERENCE IN MILWAUKEE

The National Society for the Prevention of Blindness will hold its annual conference May 14, 15, and 16 at the Pfister Hotel in Milwaukee. Panel discussions, seminars and papers on the latest developments in detecting and combating potentially-blinding eye diseases, community-action eye health programs, and programs for achieving industrial and school eye safety will be presented.

Leading off the three-day meeting will be the "Review of Current Scientific Progress," Wednesday afternoon, May 14. The panel will be chaired by Dr. Ralph E. Teitgen, Chairman of the Medical Advisory Committee of the Wisconsin Society for the Prevention of Blindness, and Assistant Clinical Professor of Ophthalmology at Marquette School of Medicine in Milwaukee.

Panel members will include Dr. Charles D. Kelman, the Director of Cataract Research and Attending Surgeon, Manhattan Eye, Ear and Throat Hospital, New York, who will explain his work with "Ultrasonic Cataract Surgery" in a slide-film presentation. Dr. Matthew D. Davis, Associate Clinical Professor of Ophthalmology at the University of Wisconsin Medical School in Madison, will discuss "Diabetic Retinopathy."

Among the other presentations slated for the afternoon session are: "Plastic Surgery in Prevention of Blindness," by Dr. Alston Callahan, President of the Eye Foundation, Inc., Birmingham, Alabama; "Syphilis and Ocular Complications," by Dr. Walter E. Gager, Assistant Professor of Neuro-ophthalmology, Marquette School of Medicine, Milwaukee; and "Corneal Disease Research," by Dr. Richard O. Schultz, Professor and Chairman of Marquette's Department of Ophthalmology.

Some 200 members of the medical and paramedical community are expected to attend the Wednesday session. Members of the State Medical Society of Wisconsin in town for the Thursday (May 15) meeting of the Section on Ophthalmology are encouraged to attend.

The annual conference luncheon will be held Thursday, May 15. Dr. Sidney Shindell, Chairman of the Division of Preventive Medicine, Marquette School of Medicine, will speak on "Prospects for Prevention."

Further information on the scientific session, the annual luncheon, and other conference offerings is available from the Wisconsin Society for the Prevention of Blindness, 312 East Wisconsin Avenue in Milwaukee; telephone: 272–0548.

ANNUAL MEETING OF SECTION

Members are reminded of the annual meeting of the Section on Ophthalmology to be held Thursday, May 15, in conjunction with the annual meeting of the State Medical Society.

The scientific program starts at 9 a.m. in the Sheraton–Schroeder Hotel. The luncheon at 12:30 will be followed by the business meeting. Scientific presentations resume at 2 p.m. with Dr. Alston Callahan of Birmingham, Ala., and Dr. Harry A. Easom of Milwaukee on the program. Complete details appeared in the March issue.

The Milwaukee Ophthalmological Society will host a dinner meeting in the evening at the University Club, starting at 6:30. Doctor Callahan will be guest speaker. Interested physicians are welcome.

MOVIE PROGRAM AT STATE MEETING

Dr. Gordon Backer of Wausau has arranged the movie program for the Ophthalmology Section at the annual meeting of the State Medical Society May 15 in Milwaukee.

The movies will be shown in Room 504 of the Hotel Sheraton–Schroeder between 9 a.m. and 12 noon. The first film, "Developmental Embryology of the Eye," will be shown from 9:00 until 9:45 a.m. This film continues to be of interest to all ophthalmologists.

From 9:45 until 10:30 a.m. surgical films will be shown from an available selection, depending on the interests of the audience. From 10:30 until 12:00 noon the above program will be repeated. □

NEWS HIGHLIGHTS

MUSEUM OF MEDICAL PROGRESS

Display Shows Benefit of Camping for Health

One of the unusual collections of interesting memorabilia at the Museum of Medical Progress in Prairie du Chien is entitled, "Camping for Health."

The display was made possible by the generosity of Mr. and Mrs. Haskell Woldenberg of Madison who, for 27 years, directed Camp Indianola for Boys on Lake Mendota.

Their gift to the Foundation was made to "encourage camping as a means of building a youngster's confidence in himself, create habits of promptness and resourcefulness, and teach them to live with each other, all of which builds character."

The display includes totem poles, Indian burial remains, and skillfully done examples of arts and crafts.

The Woldenbergs were leaders in developing organized camps with high standards of health, safety, and professional leadership.

MUSEUM OF MEDICAL PROGRESS
and
STOVALL HALL OF HEALTH
Prairie du Chien, Wis.
OPEN APRIL 15–OCTOBER 31

"FOOL THE EYE" ART TELLS MEDICAL STORY

Medical still-lifes by Aaron Bohrod, artist-in-residence of the University of Wisconsin, comprise a delightfully interesting part of the CES Foundation's medical art collection.

The paintings were part of a group commissioned by Eli Lilly and Company of Indianapolis, Indiana, and presented to the Foundation in 1962. Each deals with a phase of the history and progress of medicine. Each is done in the meticulously realistic style which Mr. Bohrod calls "magic realism." The Bohrod still-lifes are housed at the Museum of Medical Progress at Prairie du Chien but are available on loan to other organizations.

Another part of the CES Foundation's medical art collection is displayed at the Society headquarters in Madison. This includes works of art by Wisconsin physicians and a substantial collection depicting medical history originally commissioned for *Today's Health*, the AMA monthly magazine of health education.

FOX CITIES AREA DOCTORS were honored in February by St. Elizabeth Hospital of Appleton in appreciation of their many years of service to the community. Surrounding Sister M. Kathleen, hospital administrator, who was in charge of the appreciation dinner, are, from left: Dr. Arthur C. Taylor,* Dr. Guy W. Carlson,* Dr. Ralph Landis,* Dr. Edward F. Mielke,* Dr. Carl D. Neidhold,* and Dr. Edward J. Zeiss,* all of Appleton, and Dr. W. H. Towne,* Hortonville. (Photo courtesy APPLETON POST–CRESCENT)

PHYSICIAN BRIEFS

Dr. Leland Pomainville*

. . . Wisconsin Rapids, addressed the North Wood County Historical Society at its annual banquet in February. Doctor Pomainville, who is historian for the State Medical Society and vice-president of the South Wood County Historical Society, spoke on "The Life of William Beaumont As It Affected Wisconsin and the World of Medicine."

Dr. William H. Towne*

. . . was recently cited by joint resolution of the Wisconsin Legislature for outstanding service to the people of the Hortonville area and of the state during his 62-year medical career. Doctor Towne was honored Feb. 10 by the people of Hortonville.

Dr. William T. Russell*

. . . Sun Prairie, and Dr. Garrett Cooper,* Madison, have been selected to serve on a committee which will examine existing patterns of public health services in Dane County. The committee was formed by Gregory Griffin, executive director of the Health Planning Council of Madison. Doctor Russell is chairman of the State Medical Society's Commission on Public Policy and Doctor Cooper is a member of the *Wisconsin Medical Journal's* Editorial Board.

Dr. Robert J. Samp*

. . . Madison, an assistant professor of clinical oncology and surgery at the University of Wisconsin Medical Center, is the new chairman of the Inter-Agency Council on Smoking and Health.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dr. Gerald T. Scanlon

. . . has been appointed associate professor of radiology at Marquette School of Medicine and chief of diagnosis at Milwaukee County General Hospital.

Doctor Scanlon had been on the staff of Yale University School of Medicine since 1963. He received his MD degree and took his residency training in radiology–nuclear medicine at New York University Medical College, Syracuse, N.Y. He is regarded as an expert in lymphography. Doctor Scanlon resides in Wauwatosa.

Dr. Anthony R. Curreri*

. . . and Dr. John Rankin of the University of Wisconsin Medical School were elected recently to three-year terms on the administrative committee of the UW's Consultation Practice Plan.

Dr. Derward Lepley, Jr.*

. . . who performed the first heart transplant operation in Wisconsin, was initiated into the Marquette University Chapter of Alpha Sigma Nu, Jesuit honor society for men, March 16.

Dr. Hubert V. Moss*

. . . recently opened an office in Doctors Park in Madison. His practice is limited to diseases of the skin. Doctor Moss is a diplomate of the American Board of Dermatology. He received his medical degree from the Medical College of Virginia, Richmond, Va. He came to Madison after completing a two-year tour of duty as a dermatologist at Andrews Air Force Base Hospital in Washington, D.C. He also is serving as a clinical instructor in dermatology at the University of Wisconsin Medical School.

Dr. A. H. Stahmer*

. . . Wausau, recently was appointed to a one-year term on the finance committee of the American Academy of General Practice.

A "Cluster" Outbreak of Multiple Myeloma, Studied in Minnesota

What may be medical history's first "cluster" outbreak of multiple myeloma is being intensively studied by both private and government health investigators in a small Minnesota town.

This fact was revealed in a recent report in *Medical Group News,* a monthly tabloid circulated to physicians in group practice.

According to the report, Mayo Clinic physicians have joined with epidemiologists from the U. S. Communicable Disease Center and with some of the dozen doctors of Thief River Falls, Minnesota, to determine possible etiology.

The leukemia-like ailment kills at least 3,500 Americans annually; at last report, one of the patients in Thief River Falls already had died.

Health authorities point out, the report stated, that the cluster of six patients cannot be characterized as an epidemic. The cases discovered in the past six months represent an incidence which is 45 times the national rate of 1.8 cases per 100,000 population. Thief River Falls, an agricultural community in northwestern Minnesota, 60 miles from the Canadian border, has a population of 7,150.

Dr. Robert A. Kyle, a Mayo Clinic hematologist, is credited with uncovering the cluster partly by chance while doing research on leukemia. As the patients were individually referred to Doctor Kyle over a period of several months, he came to realize the significance of their community origin and the environmental and family associations of the group.

When the sixth "strongly suspect" case came to Doctor Kyle's attention in February, the Communicable Disease Center in Atlanta, Ga., had already assigned its leading "cluster chaser," Dr. Clark S. Heath, Jr., to look into the phenomenon, the *News* reported. At last report, Doctor Heath had not drawn any meaningful conclusions.

ALCOHOL INVOLVEMENT; DEC. DRIVER DEATHS

Figures released Feb. 5 by the State Division of Health on blood tests from 31 motor vehicle drivers killed in December 1968, show that alcohol was involved in 19 with 15 at or above the legal intoxication level. For the full year of 1968, the Division's blood testing program showed alcohol involvement in 275 out of 423 driver deaths reported, with 148 at or above the legal intoxication level of 0.15 percent.

State law requires blood samples to be tested for alcohol content on motor vehicle drivers and pedestrians, age 16 and over, who die within six hours of their accident.

Blood Banking Certification for Medical Technologists

A scholarship awards program that will enable medical technologists to acquire certification in blood banking has been established by the American Association of Blood Banks, the organization has announced.

The B. B. certification is conferred jointly by the AABB Committee on Education and the Registry of Medical Technologists of the American Society of Clinical Pathologists.

Under the new program, interested individuals and companies may sponsor scholarship awards which will take the form of grants made to schools approved by the AABB for education in blood banking. The medical director of each approved school will then select the technologist most deserving of the scholarship award.

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Dr. Robert G. Zach*

. . . radiologist with The Monroe Clinic, was named president of the State Medical Examining Board during its annual meeting in January. He was vice-president in 1968.

Dr. Raymond E. Burrill*

. . . Marshfield Clinic, Marshfield, will be installed as a fellow of the American College of Obstetricians and Gynecologists at its annual meeting to be held April 28 through May 1 in Bal Harbour, Fla.

Dr. Arthur W. Hoessel*

. . . Wausau, recently took over the office of president of the Wausau Chamber of Commerce.

Dr. Thomas J. Cox*

. . . of Milwaukee was named president of the Milwaukee Academy of General Practice at its annual meeting in February.

CONTRIBUTIONS—CES FOUNDATION

February 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for February 1969:

Nonrestricted

State Medical Society	Voluntary contributions of 911 MDs
Dr. & Mrs. Frederick H. Wolf	Memorial: John Cross, MD
Dr. & Mrs. Frederick H. Wolf	Memorial: Son of Dr. and Mrs. Paul Cunningham
Dr. & Mrs. Frederick H. Wolf	Memorial: Walter Jones, MD
Dr. & Mrs. Frederick H. Wolf	Memorial: Mr. Hubert Fuller
E. J. Nordby, MD	Memorial: Edward Burns, MD
Dane County Medical Society	Memorial: Edward Burns, MD
Charles W. Stoops, MD	Memorial: Edward Burns, MD
Robert B. Murphy	Memorial: Edward Burns, MD
Robert B. Murphy	Memorial: Mr. Norwood T. Bryant
Robert B. Murphy	Memorial: Mrs. Florence Bittner
Robert B. Murphy	Memorial: Mrs. Myrtle Benjamin
State Medical Society	Memorial: Francis P. Neis, MD
State Medical Society	Memorial: Isaac E. Levitas, MD
State Medical Society	Memorial: Robert G. Washburn, MD
State Medical Society	Memorial: Edward M. Burns, MD

continued on next page

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Nonmedical Trustees Named to Foundation

Three businessmen and a judge have been named trustees of the State Medical Society's Charitable, Educational and Scientific Foundation. They are: County Judge Carl Flom, Madison; L. O. Graf, Milwaukee, president of Graf's Beverages; Donald S. DeWitt, Oconto, president of the First National Bank of Oconto; and George Becker, Fond du Lac, a vice-president of Giddings and Lewis.

The Foundation's medical student loan fund currently provides $175,000 in low-interest loans to 144 students. Since its establishment in 1955, the Foundation has contributed more than $600,000 to projects of charity, professional and public health education, and scientific research.

Dr. Kroncke Society Speaker

Dr. George M. Kroncke* of the University of Wisconsin, Madison, presented the following topics at the February meeting of the Manitowoc County Medical Society: "Surgical Management of Cardiovascular Problems" and "Surgical Aspects of Coronary Artery Disease."

CES FOUNDATION CONTRIBUTIONS *continued*

Museum of Medical Progress	
State Medical Society	Voluntary contributions of 20 MDs
Will Ross Foundation, Inc. and Wisconsin Nurses Association	Exhibit: History of Nursing in Wisconsin
Student Loans	
State Medical Society	Voluntary contributions of 237 MDs
Mrs. Anna W. Dorr	Memorial: Peter M. Dorr
Charitable	
State Medical Society	Voluntary contributions of 100 MDs
Scientific Teaching	
State Medical Society	Voluntary contributions of 41 MDs
Donations Other than CESF Projects	
State Medical Society	Voluntary contributions of 127 MDs
Wisconsin Academy of General Practice Loan Fund	
State Medical Society	Voluntary contributions of 6 MDs
Danforth Medical Student Loan Fund	
State Medical Society	Voluntary contributions of 1 MD
N. J. Salt	Memorial: Mr. Lawrence Geisler
Mrs. Quincy Danforth	Voluntary contribution
J. H. Houghton, M.D. Medical Student Award	
State Medical Society	Voluntary contributions of 1 MD
Dr. & Mrs. Frederick H. Wolf	Memorial: Dr. and Mrs. J. H. Houghton
General Scholarship Fund	
State Medical Society	Voluntary contributions of 1 MD
General Memorials	
State Medical Society	Voluntary contributions of 14 MDs
Tormey Memorial Fund	
Thomas W. Tormey, Jr., MD	Memorial: Edward Burns, MD
W. W. Hildebrand Memorial Account	
William B. Hildebrand, MD	Voluntary contribution
Minnesota Medical School	
H. J. Kief, MD	Memorial: Thomas Lubitz

Dr. Anthony J. Truszkowski*

. . . a native of Milwaukee, was promoted recently to lieutenant colonel by Major General Philip Mallory, commander of the Walter Reed Army Medical Center. Doctor Truszkowski is Chief, Attending Surgeons Office, Walter Reed General Hospital.

The colonel earned his MD degree at Marquette University School of Medicine in 1958. He served his internship at St. Mary's Hospital, Milwaukee, and a residency at the Veterans Administration Center in Wood. After four years of private practice in Milwaukee, LTC Truszkowski entered the service in January 1968. He resides in Bethesda, Md.

Dr. James F. Land*

. . . Madison, recently was elected chief-of-staff of the Madison General Hospital. Others elected were: Drs. J. F. McIntosh,* vice-chief-of-staff, Paul L. Davidson,* secretary-treasurer, and trustee to the Dane County Medical Society is Dr. Glen J. Stuesser,* Verona.

Dr. Volney B. Hyslop*

. . . Milwaukee, who received the Cosmopolitan Club's Man of the Year Award in 1966, recently was honored by the Wisconsin Society of Plastic Surgeons. Doctor Hyslop, an emeritus clinical professor of plastic surgery at Marquette School of Medicine, received an engraved silver tray.

Dr. Kent E. Keller

. . . La Crosse, medical director for West Central Mental Health Clinic, has opened offices for private practice. He served three years of residency in psychiatry at University Hospitals, Madison, and was also a clinical instructor at the University of Wisconsin. Before coming to La Crosse, Doctor Keller was a consulting psychiatrist at Iowa County Hospital, Dodgeville, and was a staff psychiatrist at Mendota State Hospital, Mendota, Minn.

Dr. John Cleary

. . . Middleton, recently opened his office for the practice of general medicine and psychiatry. He graduated from the University of Wisconsin Medical School in 1959 and worked with the State Division of Vocational Rehabilitation before entering the Army.

Dr. Victor S. Falk*

. . . Edgerton, who has been the city health officer for 20 years, recently resigned his position.

Dr. Orville E. Damp*

. . . Birnamwood physician for 34 years, recently accepted a position on the medical staff of Grand Army Veterans Hospital at King. Doctor Damp served Birnamwood, Eland, Aniwa and the towns of Plover and Norrie.

Early in March some 300 friends and former patients of Doctor Damp honored him at a testimonial dinner in the Birnamwood high school.

Dr. John W. Bunke*

. . . a native of Waukesha, will be installed as a fellow of the American College of Obstetricians and Gynecologists at its annual meeting April 28 to May 1 in Bal Harbour, Fla.

Doctor Bunke is currently at the U. S. Naval Submarine Medical Center at New London, Conn.

Dr. G. E. Collentine, Jr.*

. . . director of the burn center at St. Mary's Hospital in Milwaukee, spoke at the 13th annual postgraduate course in trauma, offered by the Chicago Committee on Trauma of the American College of Surgeons, April 16–19 in Chicago.

Dr. Ralph C. Frank*

. . . Eau Claire, has been reappointed to the Council on Health by Gov. Warren P. Knowles. His term will expire July 1, 1976.

Look for Medical History Markers in Wisconsin

Have you seen medicine's historical markers in Wisconsin? Here are four that have been identified and erected by the CES Foundation of the State Medical Society:

Evergreen Park Cottage Sanatorium, at Highways F & B, Lake Nebagamon, commemorating the first tuberculosis sanatorium in the state in 1903.

Nicholas Senn, MD (1844–1908), marker at 3rd and Juneau Streets, Milwaukee, honoring the "great master of abdominal surgery" and the 49th president of the AMA.

St. Mary's Hospital marker, 2320 North Lake Drive, Milwaukee, commemorating the first civilian hospital (as that term is now understood) in Wisconsin, 1848.

Harmon Van Dusen, MD (1803–1885), marker in the City Cemetery, Mineral Point, honoring this pioneer physician, charter member of the Territorial Medical Society (predecessor of the SMS) and three times its president.

Do you have suggestions for other markers? Contact the CES Foundation.

MEETINGS *continued*

26 Inter-hospital Coordinating Disaster Committee

27 *SMS Commission on Health and Natural Resources (Wisconsin Dells)*

27 Nursing Education Committee, Dane County Heart Unit

27 SMS Committee on Military Medical Service

28 Preceptors and Faculty of University of Wisconsin Medical School

30 SMS Division on Rehabilitation

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MARCH 1969

3 Legislative Advisory Committee of Wisconsin Association of Professions

3 Insurance Advisory Committee of Dane County Medical Society

4 Surgical Staff of Madison General Hospital

4 Madison Urological Society

4 Madison Anesthesiology Society

4 Board of Trustees of Dane County Medical Society

5 SMS Commission on Public Policy

6 Senior Students of University of Wisconsin Medical School

6 Executive Committee of SMS Charitable, Educational and Scientific Foundation

10 Utilization Review Plan of Dane County Medical Society

13 UW and SMS In-Depth Teaching Program

13 Board of Directors of Wisconsin Association of Professions

16 SMS Division on Nervous and Mental Diseases

18 SMS Division on Maternal and Child Welfare and Maternal Mortality Study Committee

19 SMS Woman's Auxiliary Legislative Day (Madison)

19 Planning Committee of Wisconsin Regional Medical Program

20 Executive Committee of WPS Charge Card Corporation

20 Executive Committee of SMS Commission on Medical Care Plans

21 SMS Advisory Committee on Utilization Review

22 Wisconsin College Health Association

23 Council of Wisconsin Psychiatric Association

25 Dane County Medical Assistants Society

26 Cardiology Study Committee of Wisconsin Regional Medical Program

26 SMS Council Committee on Grievances

continued in adjacent column

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Health Resources Statistics: 1968

A report published recently by the National Center for Health Statistics compiles statistical information on manpower and facilities in the health field.

This publication, *Health Resources Statistics Reported by the National Center for Health Statistics, 1968,* provides statistics on 125 health professions and occupations, and 31,000 inpatient health facilities.

Statistics are included on trends in the numbers of persons employed in the health field, certification, registration, association membership, places of employment, and on other identifying factors.

In addition, statistics are presented on the trends in the numbers of facilities and beds for all inpatient health facilities in the United States, including short-stay hospitals, long-stay hospitals, nursing homes, and other health and correctional facilities, and the location of such facilities.

Copies of this report, (Public Health Service Publication No. 1509, 1968 edition) may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, at $2.50 each.

SUMMER CAMP FOR DIABETIC CHILDREN

The summer camp for diabetic children will be conducted for the twenty-first year under the auspices of the Diabetes Association of Greater Chicago from July 20 through August 10 at Holiday Home, Lake Geneva. Boys and girls from 8 through 13 years of age are eligible.

As in previous years, the camp will be staffed by resident physicians, nurses, dietitians and laboratory technicians, in addition to the regular counseling and domestic staff of Holiday Home.

Rates for the summer camp are arranged in accordance with individual circumstances.

Applications may be obtained from, and inquiries should be directed to: DIABETES ASSOCIATION OF GREATER CHICAGO, 620 North Michigan Avenue, Chicago, Ill. 60611; tel. 943–8668.

Coronary Care Nursing Program at La Crosse

A series of programs dealing with Coronary Care Nursing is being held at St. Francis Hospital, La Crosse, for nurses in the tri-state area. The programs are being held on Thursdays starting at 1:00 p.m. in Marycrest Auditorium at the hospital.

The series began March 13 and will continue through May 15. Any interested nurses can contact Mrs. DuWayne Johnsrud, Inservice Coordinator at St. Francis Hospital.

DOCTORS NAMED TO DRUG COMMITTEE

A 10-member task force to study legal and medical aspects of drug abuse was created by Attorney General Robert W. Warren in March.

The study group includes doctors, attorneys, and criminal investigators. It will advise the assembly state affairs committee in its investigation of the drug problem, according to Attorney General Warren.

Committee members are: John W. Calhoun, administrator of legal services in the attorney general's office; Peter Peshek, an assistant attorney general; Charles M. Wilson, administrator of the state crime laboratory; Frank Kozelka, a crime laboratory staff member; Dr. Arnold Ludwig, Mendota State Hospital; Dr. Richard Pyle,* Central State Hospital; Drs. S. Joseph Benforado, Robert Morris, and Henry A. Peters* of the University of Wisconsin, and Dr. Peter R. Moore, Madison.

Dr. L. L. Hanley*

. . . was given an appreciation banquet in the Whitehall high school late in February. The Whitehall Lions Club and other civic organizations cooperated in the tribute to the doctor who joined the staff of the Krohn Clinic in Black River Falls April 1.

Dr. Frank Roemhild

. . . a general practitioner, opened his office in the Whitehall Clinic early in March. He received his MD degree from the University of Illinois and then interned at University Hospitals in Madison before starting practice in Ames, Iowa.

Dr. Albon W. Overgard*

. . . started a "second career" early in March when he joined the medical staff of the Veterans Hospital at Fort Snelling, Minn.

After 37 years of serving the Stanley community, Doctor Overgard, at age 65, decided to "take life a little easier." At Fort Snelling he will be examining war veterans and estimating their disability.

Prior to his leaving Stanley, a number of special farewell parties honored the doctor and his family. The Overgards have taken an apartment in Farmington where their daughter and her family reside.

Dr. Leslie W. Tasche*

. . . of Sheboygan is author of a paper entitled, "1700 Vaginal Hysterectomies—In a General Practice," published in the December 1968 issue of *Minnesota Medicine.* This is believed to be the largest series of vaginal hysterectomies ever reported in a general practice.

Dr. Jack R. Hoffman*

. . . and Dr. Michael Mehr,* Waukesha internists, were named recently to the Waukesha county health board to fill vacancies created when members, Dr. John R. Guy* Waukesha, and Dr. W. E. Rosenkranz,* Mukwonago, each resigned.

Help the Needy!

This patient may appear to "have everything" but, like so many people getting along in years, she may well be in need—*medically*. Though there is no evidence of organic disease, she does have symptoms (fatigue, vague aches and pains, malaise) that may be indicative of—

a need to maintain anabolic balance... to counteract declining gonadal hormone secretion and forestall premature degenerative changes related to estrogen deficiency;

a need for mood elevation... to impart a gentle emotional uplift;

a need for nutritional supplementation... to compensate for the poor eating habits and subsequent dietary insufficiency of so many older people.

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2. **Methamphetamine** to provide gentle elevation of mood.

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	Each MEDIATRIC® Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC® Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsic.	30.0 mg.	—
Ascorbic acid	100.0 mg.	—
		Contains 15% alcohol†

† Some Loss Unavoidable.

Contraindication: Carcinoma of the prostate, due to methyltestosterone component.

Warning: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

Side Effects: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

Suggested Dosages: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

Supplied: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

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Dr. Aaron Grossman

. . . a native of Milwaukee, has been appointed professor and chairman of the department of pediatrics at the Chicago Medical School/University of Health Sciences. He has been a member of the CMS faculty for over 20 years. He received his bachelor's degree from the University of Wisconsin and earned his medical degree at the University of Chicago Medical School.

Dr. Anthony R. Curreri*

. . . professor and chairman of the Department of Surgery, University of Wisconsin Medical School, Madison, and a member of the Board of Directors of the Wisconsin Division of the American Cancer Society, was a guest lecturer at a statewide conference for registered professional nurses April 18 at the Wisconsin Center in Madison. His subject was "Basic Information We Should All Know About Cancer."

Dr. Ann Marie Travis

. . . has been appointed assistant professor of neurology at Marquette School of Medicine. Since 1965, Doctor Travis served as a staff neurologist at the Veterans Administration Hospital in Tomah. She studied at the University of Wisconsin, receiving her PhD degree in neurophysiology from the Graduate School and her MD degree from the Medical School. She took her neurology training at the National Hospital, London, England; University Hospital, Minneapolis, Minn.; and the VA Hospital, Goatsville, Pa. Doctor Travis resides in Wauwatosa.

Dr. Arthur J. Macht*

. . . Marshfield psychiatrist, and Dr. James R. Heersma,* Marshfield pediatrician, were among the speakers for a six weeks' class on "Understanding Your Primary Grade Child," during February and March at the Wisconsin Rapids Vocational, Technical, and Adult School.

NEW OFFICERS NAMED PSYCHIATRIC GROUP

At the annual meeting of the Wisconsin Psychiatric Association Feb. 1, the following officers were elected for one-year terms starting in May following the American Psychiatric Association annual meeting:

President-elect—Dr. Herman P. Gladstone,* Madison; secretary—Dr. Steven V. Hansen,* Wauwatosa; treasurer—Dr. Fred H. Koenecke,* Madison (reelected); and councilors—Drs. William H. Heywood,* Marshfield, and Paul G. Stein,* Milwaukee.

Dr. Albert A. Lorenz* of Eau Claire currently is president; Doctor Gladstone, secretary.

Brown County Supports Medical Vocations Film

The Brown County Medical Society recently supported the development of a 20-minute program on medical vocations prepared by Northeastern Wisconsin In-School Television, a nonprofit organization. The program was shown March 14 to sixth, seventh, and eighth graders of those schools who subscribe to the Television service. In addition, videotapes and 16 mm movie programs have been made available for those schools without the Television service.

WIS. MEDICAL ALUMNI DIRECTORY ISSUED

More than 1,450 University of Wisconsin-trained physicians reside in the state, at least one in 67 of its 72 counties.

Over 400 live in Madison and another 350 in metropolitan Milwaukee, according to the recently issued *1969 Wisconsin Medical Alumni Directory*.

The directory, compiled by the Wisconsin Medical Alumni Association and using a computer output for text, recently was mailed to all alumni.

Each of the 50 states has Wisconsin-trained physicians. After Wisconsin's 1,468 alumni, California, Illinois, New York, and Minnesota have the most. Delaware with one, and Alaska and Maine with two, have the fewest.

Marshfield Clinic Receives Lung Disease Study Grant

Physicians and scientists of the Marshfield Clinic in January were assured continuance of their study of farmer's lung disease begun in 1960 following a grant of $73,230 from the National Institutes of Health.

The study is under the direction of Dr. Dean A. Emanuel* and Frederick J. Wenzel through auspices of the Marshfield Clinic Foundation for Medical Research and Education which was awarded the grant.

NEW ADMINISTRATOR MT. SINAI HOSPITAL

Henry R. Karpe was recently named administrator of Mount Sinai Hospital of Milwaukee. A fellow of the American Hospital of Administrators, Mr. Karpe was formerly administrator of Mount Sinai Hospital Medical Center of Chicago, and previously had been affiliated with Sinai Hospital of Detroit, Mount Sinai Hospital of Cleveland, and the Long Island Jewish Hospital in New York.

Kenosha Foundation Gift

The Kenosha Medical Foundation recently gave $5,000 to the Kenosha Achievement Center. The check was presented by Dr. Gene F. Armstrong,* president of the Kenosha County Medical Society on behalf of the Foundation, to Mrs. Michael B. Thompson, president of United Cerebral Palsy, and William Hearron, executive director of the KAC. Dr. John N. Richards* was responsible for initially presenting the KAC program to the Medical Foundation.

Interested in Foreign Service?

American Doctor (AMDOC) has a Foreign Service Team Preceptorship Program that combines the teaching talent of the physician with the searching soul of the student into a team approach style of service on foreign soil. Specifically, one or two doctors are matched with from one to three medical students and assigned through AMDOC to an overseas station that wants and needs help.

AMDOC is a non-profit, nonsectarian, non-governmental related corporation with no aim to proselytize. It is dedicated to the ultimate placement of hundreds of physicians (and now students) into suitable needy locations.

AMDOC's global scope includes hospitals and clinics in Central America, South America, the Far East, Southeast Asia, the Near East and Africa.

It catalogues and files medical information, sociological data, status of education, agrarian and dietary information, personnel, weather, habits, clothing, and the like on each location.

Further information about AMDOC and its program can be obtained by writing to: AMDOC, Inc., 27 E. Canon Perdido Street, Santa Barbara, Calif. 93101.

UNIVERSITY SEEKING BONE MARROW DONORS

Bone marrow donor candidates are being sought in the University of Wisconsin Medical Center to help establish a pool that will provide compatible matches for children who have none in their own families.

The donor pool will assist in the experimental bone marrow graft procedure that could eliminate leukemia in some of the 40 children now awaiting possible transplants. One hundred persons already are members of the voluntary pool.

Initial testing involves only a small sample of blood. Interested persons should phone Dr. Elizabeth Silverman at (608) 231–2956, days or evenings.

CANCER RESEARCH GRANTS TO MILWAUKEE SCIENTISTS

Four cancer research grants totaling $9,150 were awarded recently to Milwaukee scientists by the Milwaukee Division of the American Cancer Society.

The grants went to Bryan G. Hoerl, PhD, associate professor of pathology, Marquette University School of Dentistry, $1,750; John C. Garancis, MD, associate professor of pathology, Marquette School of Medicine, $2,000; Bela Fodor, MD, DDS, instructor in pathology, Marquette University School of Dentistry, $600; and Joseph F. Kuzma,* MD, chairman, department of pathology, Marquette School of Medicine, $4,800.

La Crosse County Medical Society Makes Donations

At the January meeting of the La Crosse County Medical Society it was announced that a memorial of $100 in honor of Dr. Walter J. Jones, former La Crosse health officer who died Dec. 26, 1968, had been given to the Shriners Hospital for Crippled Children at Minneapolis and $200 had been contributed to the Biafra Relief Fund.

Dr. Edward Orman,* new medical director of the La Crosse County Guidance Clinic, spoke at the meeting on the problems of alcoholism, juvenile delinquency, and senior citizens.

Senator Nelson to Speak

The Honorable Gaylord A. Nelson, United States senator from Wisconsin, will address members of the State Medical Society during the annual meeting in Milwaukee, on Wednesday, May 14, at 9:45 a.m. in the Ballroom of Hotel Sheraton–Schroeder. □

Dr. Richard A. Holmes

. . . of Marquette School of Medicine spent February and March at Ankara University, Ankara, Turkey, under appointment by the International Atomic Energy Agency, Vienna, Austria. Doctor Holmes, an expert in nuclear medicine, is training the local staff in the use of radioisotopes for research and medical purposes. His work also includes initiating and conducting research programs, and improving present techniques in radioisotope studies.

Dr. Charles E. Reed*

. . . professor of medicine at the University of Wisconsin Medical School, Madison, was elected historian of the American Academy of Allergy at its 25th annual business meeting Mar. 18 in Bal Harbour, Fla.

Doctor Reed received his medical degree in 1945 from Columbia University in New York City. Internship was served at Colorado General Hospital in Denver from 1945 to 1946. Residency training was completed in 1951 at Roosevelt Hospital in New York City.

Prior to his teaching appointment at the University of Wisconsin Medical School, Doctor Reed was an instructor in medicine at the University of Oregon Medical School.

Dr. Richard B. Anderson*

. . . a former Madison physician, has been appointed research fellow in pediatrics at Harvard Medical School. Doctor Anderson, presently associated with the Boston Children's Hospital Medical Center, received his MD degree in 1947 from the University of Wisconsin. He left Madison in January 1968 to study at Harvard after practicing as a pediatrician in Madison for several years. □

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OBITUARIES

Dr. Ralph E. Morter, 81, retired Milwaukee physician, died Nov. 25, 1968, in Milwaukee.

He was born on Feb. 20, 1887, in Lodi and graduated from the Marquette University School of Medicine in 1907. His internship and residency were served at Columbia Hospital in Milwaukee. In 1960, Doctor Morter was honored by the State Medical Society of Wisconsin for his 50 years of continuous membership.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Erma, Milwaukee.

Dr. Herman L. Shapiro, 64, Prairie du Chien, died Dec. 30, 1968, in La Crosse.

He was born on Sept. 9, 1904, in Leipsic, Ohio, and graduated from Loyola Medical School, Chicago, in 1930. He took his internship at St. Bernard's Hospital, Chicago, in 1931. Doctor Shapiro served in the United States Army Medical Corps in World War II and was awarded the Silver Star. He was a member of the National Guard and retired with the rank of Colonel.

Active in community affairs, he instructed classes in first aid for the rescue squad and firemen of the surrounding areas. Doctor Shapiro was a member of the Crawford County Health Committee and vice-president of the Day Care Board for the Mentally Retarded. He was the Crawford County and City Health Officer for more than 15 years. He was on the staff of the General Hospital and secretary of the staff of the Prairie du Chien Memorial Hospital.

Doctor Shapiro was a member of the American Academy of General Practice and had served as secretary and president of the Crawford County Medical Society. He was a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Lucille; and two sons, Donald, Madison, and Jay, Chicago, Ill.; and a daughter, Mrs. Peter Wallach, Wausau.

Dr. Francis P. Neis, 78, Thorp physician for over 45 years died Jan. 7, 1969, in Thorp.

Born Aug. 5, 1890, in Juneau, Doctor Neis graduated from the Marquette University School of Medicine in 1916 and interned at Milwaukee Trinity Hospital in 1917. He established a practice at Gilman in 1917 and served as the only medical consultant in Taylor County for five years. He was a veteran of World War I. He moved to Thorp in 1923 and practiced there until he died.

In 1966, the State Medical Society of Wisconsin honored him for his 50 years of medical practice. He served for many years as a director of the Thorp Finance Corp., and was a former president and chairman of the board.

Doctor Neis was a past secretary and treasurer of the Clark County Medical Society, a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are two sons, Francis J., Marshfield, and Philip R., Albuquerque, N.M.; and a daughter, Mrs. E. J. Klink, Albuquerque.

Dr. Isaac E. Levitas, 83, De Pere, died Jan. 16, 1969, in Green Bay.

Doctor Levitas practiced in Green Bay from 1910 until his retirement in 1965. Born on Dec. 17, 1885, Doctor Levitas graduated from Rush Medical College, Chicago, in 1908 and interned at Michael Reese Hospital, Chicago, for two years. He served as a captain in the United States Medical Corps during World War I.

Doctor Levitas was a member of the Brown County Medical Society, serving as president in 1913 when it was the Brown–Door–Kewaunee County Medical Society; the State Medical Society of Wisconsin, and American Medical Association. He also was a member and

DR. HERMAN L. SHAPIRO

Statistics: M.D., Age 64, wife, one daughter, and two sons. Practiced medicine in the Prairie du Chien area for 35 years or so. Lived in Prairie du Chien for the same length of time.

Simple statistics! You guessed who he is, he is Dr. Herman L. Shapiro. It really is not so simple, many of us come and go with only that much, but Dr. Shapiro left such a great mark and impact on the community, and on many of us. He did not just practice medicine, but actually treated people with passion. He did not just treat the body, but also the mind and soul. He had an intimate relationship with people, patients and others.

Dr. Shapiro was a community man, he spared no time or effort when he was asked to serve. He also was a generous giver.

Dr. Shapiro was a good conscientious doctor who kept his medicine up to date by continually attending medical seminars and meetings.

Dr. Shapiro worked 12 months of the year, seven days a week including Sunday, no vacation except for the last four or five years, and only with pressure applied to get him to take some time off. His main hobby and recreation was to work in his beautiful garden.

Doctors have physical problems like you and I. With Dr. Shapiro his feet bothered him, but for us he stood on those tired feet for 10–12–14– or maybe 20 hours a day.

I can't say much more here, because on the inside of this issue you will find a page of tribute to Dr. Shapiro, we know you want to read it. Any more said here will probably be a repetition and knowing Herman, he would not have wanted you to waste your time reading something twice, even if it's about him.

Dr. Shapiro left such a mark on many lives, and I know many people would like to have an ever-living memorial for him. It is one positive way for all us to express and soothe our loss of Dr. Shapiro. A memorial is set up at the People's State Bank for this purpose. Send your gift to: The Dr. Herman L. Shapiro Memorial Fund, c/o The People's State Bank, Prairie du Chien, Wis., 53821. It's not only how much you give, but also the thought that counts. We feel he did for us, now it is our turn to say out loud, "Thank You, Herman".—M. M. Shihata

Reprinted with permission from
THE PRAIRIE NEWS, Feb. 6, 1969

past president of the American Academy of General Practice and was a fellow of the American College of Surgeons. He was a life member of all five organizations. He also was a member of the Wisconsin Human Rights Committee.

Surviving are his widow, Gloria; and one son, Dr. John Robert, Cincinnati, Ohio, and a daughter, Mrs. Theodore (Ellen) Jackson, Denver, Colo.

Dr. Robert G. Washburn, 89, retired Milwaukee physician, died Jan. 20, 1969, in Milwaukee.

Born on July 1, 1879, Doctor Washburn graduated from Johns Hopkins University, Baltimore, Md., in 1904. Doctor Washburn was on the staff of Columbia, St. Mary's and Milwaukee Children's hospitals, Milwaukee, for many years.

In 1955, he was awarded a life membership in the State Medical Society of Wisconsin for his 50 years of continuous membership. He was also a member of The Medical Society of Milwaukee County and American Medical Association.

Surviving are three daughters, Mrs. Jane Gallun, Scottsdale, Ariz., Mrs. Ben W. Huberty, Kenosha, and Mrs. George W. Chipley, Whitefish Bay; and a son, William H., Lake Bluff, Ill.

DR. W. O. THOMAS

They'll use all the words in memorializing Clinton's Dr. William O. Thomas: dedicated, hard working, kindly, helpful, understanding.

Dr. Thomas was all those, and more. For more than 60 years, he served the families of the village and the surrounding area faithfully and well. He was friend, neighbor and advisor, as well as just about everyone's family doctor. He gave more liberally of himself than anyone could be expected to do, and he did so willingly—joyfully, as if he was happiest when he was needed.

No words, in fact, adequately recognize the scope of the good works of Dr. Thomas. If his pills didn't make people feel better, his presence generally would. If his professional advice didn't fill the bill, his fatherly counsel often did. If his medical practice failed to benefit the whole community, his contributions as a churchman and civic leader most assuredly benefitted everyone.

The practice of medicine, as Dr. Thomas knew it, was an intensely personal thing, mutually satisfying to him and his patients. It involved a kinship with his fellow men, that is rare indeed today. As a doctor, he considered himself fortunate to have practiced in an era of "personalized" medicine, though he recognized the need for the old ways to make way for the new.

When a man dies, at age 92 and after having given a lifetime of loyal service to his community, a feeling of loss is inevitable. But Clinton does not mourn; instead it gratefully remembers a devoted doctor and a staunch friend.

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BELOIT DAILY NEWS, Jan. 27, 1969

Dr. R. J. Klein, 52, Mequon, died Feb. 6, 1969, in Milwaukee.

Born Mar. 21, 1916, in Milwaukee, Doctor Klein graduated from Marquette University in 1938. He entered Marquette University School of Medicine in 1950 and earned his degree in 1954. He was a physician for the Electric Company until he died. He served on the medical staff of St. Mary's Hospital and was also on the medical staff of the Milwaukee Catholic Home for the Aged.

Surviving is his widow, Georgia.

Dr. Dallas V. Clatanoff, 43, associate professor of medicine at the University of Wisconsin, Madison, died Feb. 9, 1969, in Dodgeville as the result of a tractor accident on his farm in northern Iowa County.

Born Oct. 22, 1925, in Wisner, Nebr., Doctor Clatanoff graduated from the University of Nebraska College of Medicine in 1951. His internship and residency was served at University Hospitals, Madison, where he became a member of the staff.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow; three sons, John, Daniel, and William; and a daughter, Kristen, Madison.

Dr. William O. Thomas, 92, a practicing physician in Clinton since 1901, died Jan. 23, 1969, in Clinton.

Born July 29, 1876, in Rockford, Ill., Doctor Thomas graduated from the Northwestern Medical School, Evanston, Ill., in 1901, interned at St. Luke's for six months, and then started his practice in Clinton. In 1951, he was honored for his 50 years as village physician and again in 1966. He continued to keep his regular office hours until his recent illness.

Doctor Thomas served as chief of staff of Beloit Municipal Hospital, was a member and past president of the Rock County Medical Society, and a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are a son, Dr. William O., Portland, Ore.; and two daughters, Mrs. Dorothy Kelsey, Evanston, Ill., and Mrs. Eleanor Nutter, Eureka, Mont.

Dr. Edward M. Burns, 57, Madison psychiatrist, died Jan. 31, 1969, in Madison.

Born Dec. 5, 1911, in Freeport, Ill., Doctor Burns graduated from the University of Illinois Medical School in 1936 and interned at the Hospital of St. Anthony de Padua, Chicago, Ill. His residency was taken at the Philadelphia Naval Hospital and at the University of Wisconsin General Hospital, Madison. Doctor Burns served with the United States Navy in World War II. At the time of his death Doctor Burns was an assistant clinical professor of psychiatry at the University of Wisconsin, was on the staffs of St. Mary's and Madison General hospitals, and had formerly been clinical director for Mendota State Hospital.

Doctor Burns was a member of the Dane County Medical Society, State Medical Society of Wisconsin, American Medical Association, and Wisconsin Psychiatric Association. He also was a fellow of the American Psychiatric Association and a diplomate of the American Board of Psychiatry and Neurology.

Surviving are his widow, Pauline; and two daughters, Ellen, Madison, and Mrs. William H. Haring, Denver, Colo.

Dr. N. Peter Braun, 38, prominent orthopedic surgeon of Sheboygan, died Feb. 13, 1969, in Nassau, the Bahamas.

Born on May 29, 1929, in Cape Town, South Africa, Doctor Braun graduated from The Welsh National School of Medicine, Cardiff, Wales, in 1953, and interned at the Royal Infirmary there. He also did postgraduate work in London, England, New London, Conn., and Cincinnati, Ohio. Doctor Braun was located at The Monroe Clinic before joining the Sheboygan Clinic in 1962.

He was a member of the Sheboygan County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow and two children.

Dr. William Lumsden, 94, Menomonie, died Feb. 15, 1969, in Menomonie.

Born Aug. 26, 1874, in Clifton, Doctor Lumsden graduated from the Illinois Medical College, Chicago in 1905. He practiced in Clayton and Knapp before moving to Menomonie in 1918. He retired in 1963.

He was a member of the Eau Claire–Dunn–Pepin County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving is a son, Paul, Menomonie.

Dr. Thomas U. Dobbins, 83, retired Army colonel and former Kenosha resident, died Mar. 1, 1969, in Manatee, Fla.

Doctor Dobbins resided in Kenosha many years ago and was industrial surgeon for Nash Motor Corp. in Racine and Kenosha.

Doctor Dobbins was an industrial surgeon for Servel Inc., Evansville, Ind., and was associated with public health departments in three Florida counties.

Surviving are his widow, Alma Patzke; and three daughters, Mrs. Mary Louise Wheeler, Tempe, Ariz.; Mrs. Eva May Bundenthal, Seward, Neb., and Mrs. Helen Joan Haugnes, Naperville, Ill.

Dr. Vincent W. Koch, 79, retired Janesville specialist in internal medicine, died Mar. 5, 1969, in Janesville.

Born on July 27, 1889, in Janesville, Doctor Koch graduated from Rush Medical College, Chicago, in 1916 and took his internship at St. Luke's Hospital, Chicago. He served in World War I in the United States Army Medical Corps.

Doctor Koch was the author of many published articles on internal medicine and cardiology. He was a former president of Wisconsin Heart Association, was an associate preceptor of the University of Wisconsin, former president of the Rock County Medical Society, member of the State Medical Society of Wisconsin and American Medical Association.

Surviving is his widow, Ardelia, Janesville. □

DID YOU KNOW that workers disabled before age 65 who have worked long enough and recently enough under social security can get monthly cash benefits? □

DR. VINCENT W. KOCH

FEW RELATIONSHIPS in modern society are as close and personal, and inspire such gratitude, as that between physician and patient. So it is that an appreciative public remembers the family doctor.

Dr. Vincent W. Koch, who died Wednesday, refused to spare himself in his profession. He was known to be stimulating. He was recalled by nurses for his generous training classes, his interest and help, his readiness to share his experience and knowledge.

His skill and acumen in diagnosing illness was a boon to patients and his willingness to serve day or night was reminiscent of earlier medicine.

Dr. Koch served his fellow man and his country in many capacities in a distinguished career.

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JANESVILLE GAZETTE, March 10, 1969

THE PHYSICIAN AND LEGAL MEDICINE

The *Journal* of the AMA for September 7, 1963, contained an article entitled, "YOUR Professional Liability, 131 Questions and Answers." The questions include many which physicians are likely to encounter in their daily practice.

The answers follow the general rule of law in some instances, or the only rule in the case of other questions as to which there is very little court authority. This procedure was necessary when writing for physicians of the entire country but gives no assurance that the Wisconsin court has followed or will follow such rule were the same question before it. There may thus be some differences between answers given in the AMA article and those which an attorney would give to a Wisconsin physician.

The last paragraph of the introduction of the AMA article is sufficiently important to merit repetition. It states:

> "The following questions and answers do not eliminate the need for legal advice. Rather they help the physician to determine when it is necessary to call upon his personal attorney for such advice."

The article has been reprinted in pamphlet form and is available upon request to the Law Division of the American Medical Association.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JANUARY 27, 1969

NEW MEMBERS

Babbitt, Lon D., 2050 Westpoint Road, Green Bay 54301
Bauer, Deedric W., P. O. Box 803, Neenah 54956
Burrows, Thomas, 59 Racine Street, Menasha 54952
Carlson, Robert D., 630 S. Central Ave., Marshfield 54449
Cunningham, Thomas E., Oshkosh Clinic, Oshkosh 54901
Dahl, David S., 1300 University Ave., Madison 53706
Eckstrom, Philip T., 1510 Main Street, Marinette 54143
Edwards, Donald E., 1416 Commercial, Neenah 54956
Faber, John W., 1215 Doctors Drive, Neenah 54956
Grabow, Jack D., 1954 East Washington Ave., Madison 53704
Gray, John H., 211 N. Commercial Ave., Neenah 54956
Hammond, Charles, 211 North Commercial Ave., Neenah 54956
Maurer, William J., 619 Laurel Court, Marshfield 54449
Miller, Donald A., 119 Main Street, Gillett 54124
Naval, Joventino, McDonald Clinic, Winneconne 54986
Novotny, Clarence G., 1551 Dousman Street, Green Bay 54301
Papadakes, Nicholas G., 305 East Court Street, Janesville 53545
Sargent, II, Frederick, 2413 Nicolet Drive, Green Bay 54301
Wu, Jane P., 4722 Fond du Lac Trail, Madison 53705

CHANGES OF ADDRESS

Altman, S. David P., 2040 W. Wisconsin, Milwaukee 53233
Arndt, George W., 706 E. Forest Ave., Neenah 54956
Carney, Cyril Michael, 419 Pleasant, Beloit 53511
de Gusman, Eleuterio A., W180 N8170 Destiny Dr., Menomonee Falls 53051
Fink, Donald W., Denver, Colo., to 4266 South Elm Court, Englewood, Colo. 80110
Flynn, Robert E., 1431 King Street, La Crosse 54601
Garrison, Rogers E., 731—3rd Street South, Wisconsin Rapids 54494
Gomilla, Severino G., Kenosha, to 2420 E. Newberry, Appleton 54911
Holder, Donald H., Milwaukee, to 531 Main Street, Green Bay 54301
Iber, Frank C., 1408 Division Street, Stevens Point 54481
Kolmeier, Karl H., 4623 Parkridge Dr., Racine 53401
Konicek, Robert George, 1735 Third Avenue, Northwest, Rochester, Minn. 55901
Lee, Connie Corlet, La Farge, to 526 E. Brown Street, Waupun 53963
Litofsky, Arthur, Reisterstown, Md., to 1015 Spring Street, Silver Spring, Md. 20910
Lucas, Andrew M., 1011 Third Street, South, Wisconsin Rapids 54494
May, Joseph H., Maribel, to 903 North 24 Street, Manitowoc 54220
McCormick, Donald W., 2080 Tower Drive, Fond du Lac 54935
Nishoika, Hiro, 2221 S. Webster Ave., Green Bay 54301
Osicka, Steve R., 134 S. Adams Ave., Berlin 54923
Ostenso, Richard S., 1412 South Hastings Way, Eau Claire 54701
Springberg, Joseph Charles, 419 Pleasant, Beloit 53511
Verdone, Anthony J., 6014 West Congress St., Milwaukee 53218

REMOVED FROM MEMBERSHIP

Cline, David W., Dane County, transferred to Minnesota
Lappley, Walter F., Dane County, resigned
Rian, Oliver, Door–Kewaunee County, transferred to Illinois

Correction from last membership report

Brown, John F., Waukesha County reported as Oneida–Vilas County

DEATHS

Neis, Francis P., Clark County, Jan. 7, 1969
Levitas, Isaac E., Brown County, Jan. 16, 1969
Washburn, Robert G., Milwaukee County, Jan. 20, 1969
Burns, Edward M., Dane County, Jan. 31, 1969 □

WISCONSIN HEALTH

By E. H. JORRIS, MD, State Health Officer

NEW METHOD MAY AID CANCER SEARCH

At present rates, one of every four persons will have cancer in their lifetime, and one in every six will die from the disease. Hopefully, we can increase the cure rate in future years as we have in the past. During the last 50 years, for example, cancer cure rates have increased from one in ten to one in three.

The impact of early detection in curing cancer is well documented by the use of the "Pap" or cytologic smear test for cancer of the uterus.

If all adult women had yearly cytologic smear tests, deaths from uterine cancer would become rare. Yet only about one-fourth of the million women in this age group in Wisconsin have a smear test yearly.

A simplified technique of taking and reading smear samples is under study by the Division of Health, with assistance from the medical profession. This method is designed to greatly reduce the burden on physicians for taking samples and to relieve medical laboratories of the painstaking and time consuming microscopic examination of the samples.

The new method under study employs a cytopipette home kit that can be used by women to obtain specimens from themselves. The cytopipette kit is keyed to electronic equipment that can analyze the cellular specimens in a fraction of the time of individual microscopic analysis.

Neither the cytopipette method of obtaining specimens nor the electronic examination method can yet be hailed as the answer to widespread testing for cervical cancer. But both ideas do show promise and if the promise is fulfilled, they will make a major contribution to the goal of making uterine cancer deaths a rarity. □

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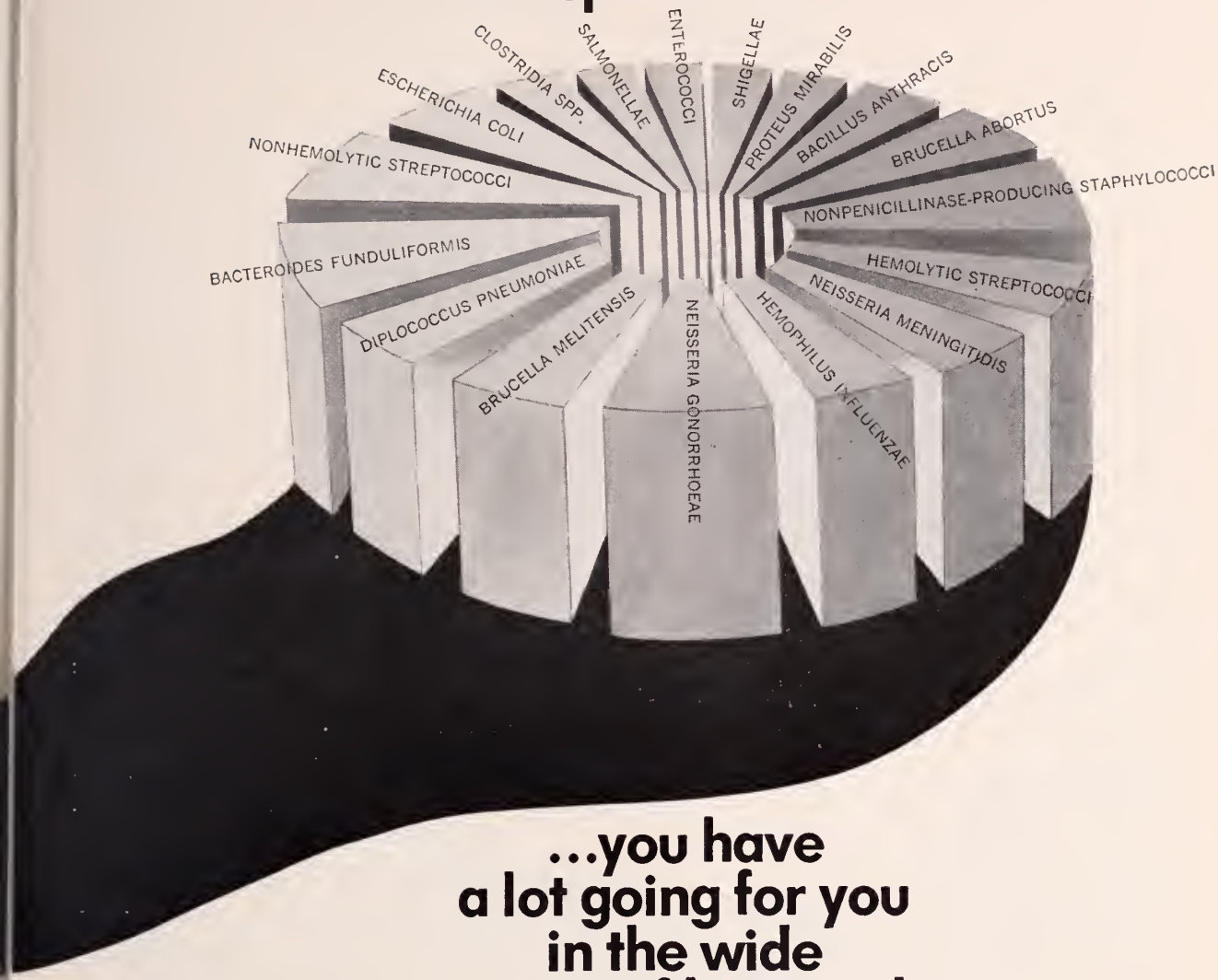

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Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.
Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.
Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.
Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.
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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706

BOOKS RECEIVED

EDUCATIONAL ATTAINMENT OF MOTHER AND FAMILY INCOME: White Legitimate Births

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 22, No. 6. U. S. Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. 46 pages. Price: 40¢

NURSING AND PERSONAL CARE SERVICES—Received by Residents of Nursing and Personal Care Homes

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 12, No. 12. U. S. Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. 41 pages. Price: 40¢

VARIATIONS IN BIRTH WEIGHT—Legitimate Live Births United States—1963

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 22, No. 8. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 35 pages. Price: 45¢

INTERVIEWING TECHNIQUES FOR THE NON PERSONNEL EXECUTIVE

By Robert M. Hecht, Joel E. Aron, and Morton D. Siegel. A Management Education Publication of the Personnel Testing Service, Inc., 342 Madison Avenue, New York, N. Y. 10017. 53 pages.

VOLUME 3 MEDICAL STAMPS HANDBOOK NO. 63

By E. Willis Hainlen, MD. Published by American Topical Association, Inc., 3306 North 50th St., Milwaukee, Wis. 53216. 1968. 87 pages. Price: $5.00

HEARING STATUS AND EAR EXAMINATION—Findings Among Adults, United States—1960–1962

U. S. Department of Health, Education and Welfare. Public Health Service. Series 11, No. 32. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 28 pages. Price: 35¢

DISABILITY DAYS

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 10, No. 47. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 55 pages. Price: 60¢

AN INTERIM GUIDE TO THE CANNABIS (MARIHUANA) LITERATURE

By Oriana Josseau Kalant. Published by Addiction Research Foundation, 344 Bloor St., West, Toronto 4, Ontario, Canada. 39 pages.

PREVALENCE OF SELECTED IMPAIRMENTS—United States, July 1963–June 1965

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 10, No. 48. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 79 pages. Price: 75¢

VOLUME OF PHYSICIANS VISITS—United States, July 1966–June 1967

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 10, No. 49, U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 60 pages. Price: 60¢

DESIGN AND METHODOLOGY FOR A NATIONAL SURVEY OF NURSING HOMES

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 1, No. 7. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 36 pages. Price: 50¢

HEALTH MANPOWER—United States 1965–1967

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 14, No. 1. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 56 pages. Price: 60¢

MIGRATION, VITAL, AND HEALTH STATISTICS—A Report of the United States National Committee on Vital and Health Statistics

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 4, No. 9. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 17 pages. Price: 30¢

DRUGS ON THE COLLEGE CAMPUS

By Helen H. Nowlis. Doubleday & Company, Inc., Garden City, New York. 1969. Anchor Books. 144 pages. Price: 95¢

WHAT YOU CAN DO ABOUT CANCER

By Joseph C. Maroon, MD. Doubleday & Company, Inc. Garden City, New York. 1969. 194 pages. Price: $5.95

RENAL DISEASE IN CHILDHOOD

By John A. James, Professor of Pediatrics, Department of Pediatrics, University of Southern California School of Medicine, Los Angeles. The C. V. Mosby Company, Saint Louis, Mo. 1968. 371 pages. Price: $18.50

INFANT AND PERINATAL MORTALITY IN ENGLAND AND WALES

By U. S. Department of Health, Education, and Welfare. Public Health Service. Series 3, No. 12. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 77 pages. Price: 75¢

CATALOG OF FEDERAL PESTICIDE MONITORING ACTIVITIES IN EFFECT JULY 1967

Department of Health, Education, and Welfare. Public Health Service. Communicable Disease Center, Atlanta, Ga. 30333. 131 pages.

COMPARISON OF THE CLASSIFICATION OF PLACE OF RESIDENCE ON DEATH CERTIFICATES AND MATCHING CENSUS RECORDS: United States—May–August 1960

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 2, No. 30. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 60 pages. Price: 60¢

PSEUDOREPLICATION—FURTHER EVALUATION AND APPLICATION OF THE BALANCED HALF-SAMPLE TECHNIQUE

U. S. Department of Health, Education, and Welfare. Public Health Service. Series 2, No. 31. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 24 pages. Price: 35¢

PSYCHOLOGICAL AND SOCIAL ASPECTS OF HUMAN TISSUE TRANSPLANTATION, An Annotated Bibliography

By Jacquelyn H. Hall, MS, and David D. Swenson, MD. National Clearinghouse for Mental Health Information, National Institute of Mental Health, 5454 Wisconsin Ave., Chevy Chase, Md. 20203. 1968. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. Public Health Service Publication No. 1838. 57 pages. Price: 40¢

SOCIOECONOMIC CHARACTERISTICS OF DECEASED PERSONS —United States—1962–1963 Deaths

U. S. Department of Health, Education and Welfare. Public Health Service. Series 22, No. 9. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 38 pages. Price: 50¢

MODERN TREATMENT

Vol. 6, No. 6. Treatment of Pain, guest editor, Richard I. H. Wang, PhD, MD, and Treatment of Neuropathies, guest editor, Robert J. Jovnt, MD, Hoeber Medical Division, Harper & Row Publishers, 49 East 33 St., New York, N. Y. 10016. Published bimonthly. 1,500 pages annually. Subscription: $16 per yr.

MODERN TREATMENT

Vol. 6, No. 1. Treatment of Restrictive Pulmonary Insufficiency, guest editor, Edwin Rayner Levine, MD, and Treatment of Liver Disease, guest editor, Fenton Schaffner, MD, Hoeber Medical Division, Harper & Row, Publishers, 49 East 33 St., New York, N. Y. 10016. Published bimonthly. 1,500 pages annually. Subscription: $16 per yr.

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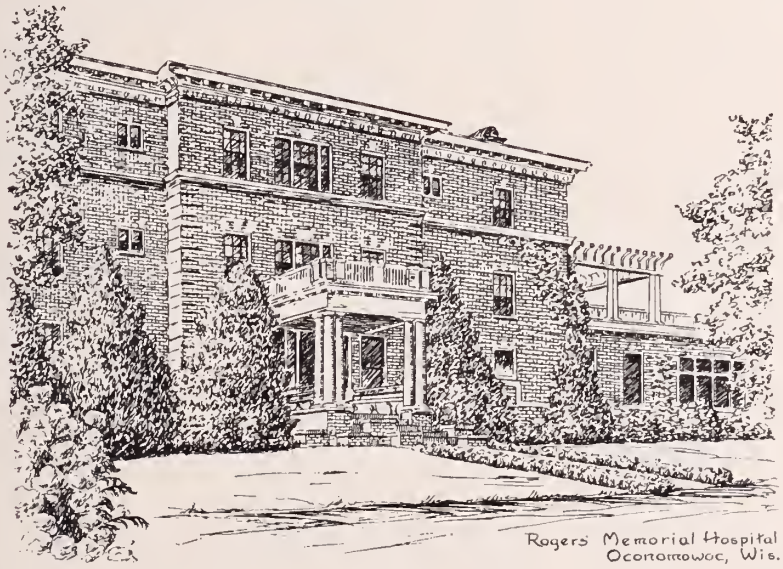

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BOOK REVIEWS

INTERFERON

Ciba Foundation Symposium, edited by G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown & Co., Boston, 1968. 284 pages. Price: $12.00.

This volume is composed of highly specialized, detailed papers presented at a symposium dedicated to the late Dr. Alick Isaacs who initially described and named interferon. The participants comprise a large proportion of the most active workers in interferon research and their formal contributions and detailed discussion sessions represent as current an assessment of the state of knowledge of this aspect of virology as is available.

Because of the degree of specialization and intricacy of discussion, the reading of this volume is an exacting task even for a virologist actively involved in parallel pursuits. A large proportion of the text is devoted to the subject of the mechanism of action of interferon, and for the general reader this section can be summarized by saying that exact answers are not yet available. A few contributions concerning experimental induction of interferon in animal models are of somewhat broader interest. While the book supplies a valuable reference source for microbiologists interested in the area, it offers little potential benefit for the generally interested clinician.—JUNE E. OSBORN, MD

INTERNAL MEDICINE—Based on mechanisms of disease

Edited by Peter J. Talso, A.B., M.D., F.A.C.P., F.A.C.C., professor and chairman, Dept. of Medicine, Loyola University Stritch School of Medicine, Hines, Ill.; and Alexander P. Remenchik, B.S., M.D., F.A.C.P., professor and asst. chairman, Dept. of Medicine, Loyola University Stritch School of Medicine, Hines, Ill. Published by C. V. Mosby Co., 1968. 797 pages. $17.50.

This textbook is aimed at the student and house officer primarily, according to the authors' preface. They have divided the work into two books within a book. After an introductory section on internal medicine as a science and an art (which could be omitted without loss to the reader), there is a section of some 200 pages devoted to basic mechanisms of disease. Included therein are genetic factors, atherosclerosis, aging and senescence, host-agent interactions in infectious diseases, immunity and host defense, neoplasia, chemical and physical agents, deficiency diseases, iatrogenic and factitious factors and psychiatric and psychologic factors. The quality of these chapters is quite spotty, some being excellent (e.g., genetic factors, neoplasia, host-agent interactions, immunity, chemical and physical agents), while others (aging and senescence, deficiency diseases, iatrogenic and factitious factors) are superficial. This, then, constitutes the first of the two books.

The second book consists of some 550 pages presenting organ system diseases. Thus, there is a section each on cardiovascular, respiratory, digestive, metabolic and "miscellaneous" disease. These are generally very well done although they do not depart significantly from previous texts in their organization and presentations. The publisher has done a splendid job technically. Print is easy to read; tables, figures, illustrations are all of high quality.—EDWIN C. ALBRIGHT, M.D.

THE PEDIATRICIAN'S OPHTHALMOLOGY

Edited by Sumner D. Liebman, M.D., instructor in ophthalmology, Harvard Medical School, Boston, and Sydney S. Gellis, M.D., professor and chairman, department of pediatrics, Tufts University School of Medicine, Boston. With 25 contributing authors. C. V. Mosby Co., St. Louis. June 1966. 352 pages. Price. $19.50.

This book has great usefulness to pediatricians and academicians alike. The first chapters on the *Anatomy of the Eye and the Growth of the Eye* and *Development of Vision* are particularly valuable background information. The chapter on *Strabismus* is also a very well written and informative description of the problem. Most pediatric textbooks do not go into this much detail and pediatric interest in the area is great. The least useful part of the book are the sections on *Ocular Manifestations of Pediatric Systemic Diseases* and the descriptions of *External Diseases of the Eye.*

The printing of the book is excellent and there are many color plates. Some of the tables are extremely valuable—such as the table on the Inherited Conditions that Manifest Ocular Pathology. The Glossary of Ophthalmic Terms at the end of the book is also of value to the pediatrician. My overall appraisal of this book is that it will be an excellent addition to the pediatrician's library. It will probably be of less interest to the student and general practitioners, but an excellent reference text.—CHARLES C. LOBECK, M.D.

THE HEART—ITS FUNCTION IN HEALTH AND DISEASE

By Arthur Selzer, M.D., clinical professor of medicine, Stanford University and the University of California Schools of Medicine. University of California Press, Berkeley and Los Angeles. 1966. 301 pages. Price: $5.95.

In the Editor's Foreword on the series of books entitled "Perspectives in Medicine," the last paragraph reads as follows: "Each book will be a concise, comprehensive, and illustrated essay on a major disease, or a body system and its fundamentally related parts, or a specialized area of research, or an aspect of our society that affects the public health. Historical and sociological factors will be included where appropriate."

In this essay "The Heart—Its Function in Health and Disease" the author does what he intends to do, he presents the subject in terminology that is understandable and does it very well, accurately bridging the gap between scientific and "popular" medicine, comprising the basic background of scientific and clinical principles.

While apparently written mainly for paramedical personnel and the educated reader untrained in medicine, it is very worthwhile reading for physicians and medical students.—H. H. SHAPIRO, M.D. □

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Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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MEDICAL MEETINGS
POSTGRADUATE COURSES

1969 WISCONSIN

June 5–7: Conference on "The New Hospital Psychiatry," sponsored by the University of Wisconsin Department of Postgraduate Medicine, Department of Psychiatry, and the Wisconsin Psychiatric Institute of the University of Wisconsin Medical Center, Madison.

June 9: UW graduation day.

June 15: President's Reception, State Medical Society, Madison.

Aug. 2–3: State Medical Society Council meeting.

Sept. 4: Postgraduate course—The Dentist and Cancer Control, University of Wisconsin Medical Center, Madison.

Sept. 11–14: Annual Meeting, Wisconsin Society of Internal Medicine, Kaehlers Resort (formerly Uphoffs') Lake Delton (changed from Deer Park Lodge).

Sept. 27: Fifteenth annual fall cancer conference (Cancer Scrimmage—Wis. vs. UCLA), University of Wisconsin Medical Center, Madison.

Oct. 6–10: Wisconsin Work Week of Health, State Medical Society, to be held in five cities around Wisconsin.

Oct. 3–4: Annual meeting, Easter Seal Society of Wisconsin, Beaumont Motor Inn, Green Bay.

Oct. 8–9: Annual meeting, Wisconsin Academy of General Practice, Holiday Inn No. 2, Madison.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton–Schroeder Hotel, Milwaukee.

1969 NEIGHBORING STATES

June 10–13: Annual convention, Catholic Hospital Association, Minneapolis, Minn.

June 14: Symposium on Opportunistic Infections of the Lung, Minnesota and Wisconsin Chapters of the American College of Chest Physicians and the Communicable Disease Control Unit of the United States Public Health Service, Holiday Inn Central, Minneapolis, Minn.

Sept. 15–16: Biennial meeting of State Medical Journal Advertising Bureau, Chicago, Ill.

Sept. 22–23: Midwest Interprofessional Seminar on Diseases Common to Animals and Man, Memorial Union, Iowa State University, Ames.

Oct. 4–10: Annual Otolaryngologic Assembly of 1969, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Oct. 15: Fifth annual professional symposium on Recent Advances in Renal Disease, Kidney Foundation of Illinois, LaSalle Hotel, Chicago.

Nov. 3–14: Postgraduate course in Laryngology and Bronchoesophagology, Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago.

Nov. 8–9: North Central Medical Conference, St. Paul Hilton, St. Paul Minn.

Nov. 21–22: Workshop on the Delivery of Medical Care in the 1970s, Institute of Medicine of Chicago, Ambassador Hotel, Chicago.

Nov. 28–29: Head and Neck Radiology Conference, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Nov. 30–Dec. 5: Radiological Society of North America, Chicago, Ill.

1969 OTHERS

June 9–13: ACP postgraduate course—Neurology for the Internist, Bowman Gray School of Medicine, Winston–Salem, N. C.

June 16–19: ACP postgraduate course—Auscultation of the Heart, University of Oregon Medical School, Portland, Ore.

June 15–20: Lecture series, Flying Physicians Association, Lake Placid Club, Essex County, New York.

June 16–20: ACP postgraduate course—Hematology, University of Rochester School of Medicine, Rochester, N. Y.

July 7–11: Postgraduate Course—Clinical Electrocardiographic Interpretation Hahnemann Medical College and Hospital, Philadelphia, Pa.

July 14–18: Postgraduate course—Interpretation of Cardiac Arrhythmias, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 11–15: American Bar Association, Dallas, Tex.

Aug. 11–17: Postgraduate course—Space Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 14–16: Postgraduate course on Peptic Ulcer, American Gastroenterological Association, Aspen, Colo.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham Hotels, Washington, D. C. and Baltimore, Md.

Sept. 8–12: Fifth International Congress of Dietetics and 52nd annual meeting of American Dietetic Association, Sheraton–Park Hotel, Washington, D.C.

Sept. 28–Oct. 3: Annual meeting Michigan State Medical Society, Detroit.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 7–11: Western Conference of Prepaid Plans, Sun Valley, Idaho.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Nov. 20: Annual Membership Meeting, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psychosomatic Seminars), to South Pacific.

1969 AMA

July 13–19: Annual meeting, American Medical Association, New York City.

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

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1970 WISCONSIN

May 11–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 NEIGHBORING STATES

Oct. 5–9: 53rd Annual Meeting, American Dietetic Association, Detroit, Mich.

1970 OTHERS

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1971 OTHERS

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the **Journal of the American Medical Association.**

Pediatrics Course, Colorado

The twelfth annual postgraduate course in Pediatrics will be held at the Aspen High School in Aspen, Colo., Aug. 3–6, sponsored by the University of Colorado School of Medicine.

It is designed specifically for the practicing pediatrician to help him keep abreast of significant new developments in the broad field of pediatrics, its many branches, and related fields. All physicians with an interest in the subject and level of this course are invited to attend.

Four eminent guest speakers will participate: KEITH DRUMMOND, MD, Montreal, Quebec; ROBERT J. GLASER, MD, Palo Alto, Calif.; BENJAMIN M. KAGAN, MD, Los Angeles, Calif.; and HARVEY D. KLEVIT, MD, Portland, Ore.

This program is offered in an environment of informality, and adequate time is provided for leisure activities such as fishing, hiking, golfing, swimming, and sightseeing. The internationally famous ASPEN MUSIC FESTIVAL will be in progress at the time of the course.

Tuition: $90.00. Registrants are requested to make their own housing reservations. Reservations and information on all types of accommodations may be obtained by writing to: Miss Joan Neylands, Business Communications Center, Box 1154, Aspen, Colo. 81611. Telephone 303/925–1500. It is important that the name of this course be included when making reservations.

Course in Laryngology and Bronchoesophagology

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, will conduct a postgraduate course in Laryngology and Bronchoesophagology from Nov. 3–14. This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, MD.

It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants should write directly to the Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Ill. 60680.

Annual Otolaryngologic Assembly

The annual Otolaryngologic Assembly of 1969 will be held Oct. 4–10 in the Illinois Eye and Ear Infirmary at the Medical Center, Chicago. The Department of Otolaryngology of the College of Medicine of the University of Illinois offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Dr. Emanuel M. Skolnik. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

A separate, but correlated course, "Head and Neck Radiology Conference," this year will be held on Friday and Saturday, Nov. 28 and 29, under the guidance of Dr. Galdino E. Valvassori. For further information about the radiology course, write to Doctor Valvassori, Radiology Department, College of Medicine.

Interested otolaryngologists should direct their inquiries to the mailing address: Otolaryngology, P. O. Box 6998, Chicago, Ill. 60680.

American Dietetic Association

The American Dietetic Association will be host for two scientific meetings occurring jointly this fall. The 5th International Congress of Dietetics and the 52nd Annual Meeting of the ADA will be held Sept. 8–12 in Washington, D. C. "Dietetics in a Changing World," theme for the

continued on page 11

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DOSAGE: 1 or 2 teaspoonfuls or 1 or 2 tablets 3 times a day before meals. The feeling of warmth and tingling of the skin is a desirable effect. If this reaction is too pronounced reduce dosage.

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REFERENCES:
1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

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Congress, will focus on the role of dietitians and nutritionists in meeting the health needs of tomorrow's world.

The Sheraton–Park Hotel will be headquarters for the sessions and exhibition. Keynote speakers on Sept. 8 will discuss Social Aspects of a Changing World, Nutritional Status and the Health Potential of Our World Population, and Food Technology Changes in the World of Today and Tomorrow.

Kidney Foundation of Illinois

The Fifth Annual Professional Symposium on Recent Advances in Renal Disease will be held Wednesday, Oct. 15, from 9 a.m. to 5 p.m. in the Grand Ballroom of the LaSalle Hotel in Chicago. The program is being arranged by the Professional Education Committee of the Kidney Foundation of Illinois.

Further information may be obtained by writing to the Foundation, 127 North Dearborn Street, Chicago, Ill. 60602; tel. 312/263–2140.

Workshop: Medical Care in the 1970s

The delivery of medical care in the 1970s will be the topic of a day and a half workshop for physicians and other health leaders Nov. 21 and 22 at the Ambassador Hotel in Chicago under the sponsorship of the Institute of Medicine of Chicago.

The sessions will feature more than a dozen speakers and six group discussions on topics ranging from health care for the inner city through assessment of the roles of different types of hospitals, a medical student's view of his future, a study of health-care costs, and evaluations of the political forces which affect medicine.

A partial program has been announced by Dr. Paul S. Rhoads, chairman of the Institute's Board of Governors and convenor of the workshop. His speakers will include Dr. Dwight L. Wilbur of San Francisco, current president of the American Medical Association, Dr. Ivan L. Bennett of New York City, vice-president of New York University and formerly the President's advisor on science, and one or more members of Congress, plus a senior executive of the Department of Health, Education and Welfare.

The panelists will include the heads of urban clinics, the administrators of large and small hospitals, physicians in various types of practice, executives of health insurance programs, and health educators from across the country.

The workshop will begin Friday morning, Nov. 21 and will conclude with Dr. Wilbur's summarizing remarks before midday on Saturday.

Registration for members of the Institute will be $25 and for invited guests $40. The fee will include the two meal functions but not accommodations at the Ambassador Hotel.

Advance registrations can be made by writing to the Institute of Medicine of Chicago, 332 South Michigan Avenue, Chicago, or by completing an advance enrollment form to be circulated later in the spring. Reservations for rooms may be made directly with the Ambassador Hotel, mentioning attendance at the workshop.

Pulmonary Infections Symposium, Minneapolis

A Symposium on Opportunistic Infections of the Lung will be held Saturday, June 14, in the Hall of Satellites at the Holiday Inn Central, Minneapolis, Minn., under joint sponsorship of the Minnesota and Wisconsin Chapters of the American College of Chest Physicians and the Communicable Disease Control Unit of the United States Public Health Service.

Dr. Earl G. Yonehiro, president of the Minnesota Chapter of the ACCP, will chairman the morning session which will include the following speakers: John P. Utz, MD, Medical College of Virginia School of Medicine, Richmond; Alfred G. Karlson, DVM, PhD, Mayo Graduate School of Medicine, Rochester, Minn.; Warren J. Warwick, MD,

continued on page 13

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University of Minnesota; Richard L. Simmons, MD, University of Minnesota; William W. Stead, MD, Marquette School of Medicine, Milwaukee, Wis.

In the afternoon Dr. Robert S. Fontana, vice-president of the Minnesota Chapter of ACCP, will chairman the program which includes as speakers John E. Kasik, MD, PhD, University of Chicago; James P. Lillehei, MD, University of Minnesota; John A. Ulrich, MD, Mayo Graduate School of Medicine; Ernest C. Herrmann, PhD, Mayo Graduate School of Medicine; and R. Drew Miller, Mayo Graduate School of Medicine.

If interested, contact Robert S. Fontana, MD, Minnesota Chapter, American College of Chest Physicians, Mayo Clinic, Rochester, Minn. 55901; tel. 507/282-2511.

Wisconsin Heart Association

"Heart Transplants" will be the subject of the annual meeting of the Wisconsin Heart Association on Saturday, June 7. It will be held at the Holiday Inn Central, Milwaukee. Lecturers include Dr. Grady L. Hallman, Jr., of Houston, Tex.; Joseph R. Roth, L.L.D., of the University of Chicago; Dr. S. P. Masouredis and Dr. Derkard Lepley, Jr. of Marquette School of Medicine.

Registration for the meeting begins at 8:30 a.m. Dr. Thomas Puchner, practicing Cardiologist, Milwaukee, is chairman of the annual meeting committee. □

CLINICAL STUDY OF PROGERIA (HUTCHINSON–GILFORD SYNDROME)

The cooperation of physicians is requested in the referral of patients for a study of progeria being conducted by the National Institute of Child Health and Human Development at the Gerontology Research Center in Baltimore, Maryland. The purpose of this study will be to demonstrate whether or not characteristics of aging or senescence in man are shared by patients with progeria.

Needed are children or adolescents with typical features of progeria (cachectic dwarfism, relative normocephaly, normal intelligence, bird-like facies, bilateral coxa valga, hypoplasia of mandible, and hypoplasia of clavicles, and senile-appearing skin) and suspected or proven arteriosclerosis or atherosclerosis. Studies performed will include physiological testing, punch skin biopsy for collagen characterization and fibroblast tissue culture, cardiologic evaluation with exercise electrocardiogram, other biopsies if clinically indicated, and chromosomal analysis.

Selected patients will be admitted to the Gerontology Research Ward (at Baltimore City Hospitals) of the Gerontology Research Center. Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to this study may write or telephone:

WILLIAM REICHEL, M. D.
Gerontology Research Center, NICHD
Baltimore City Hospitals
Baltimore, Maryland 21224
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WISCONSIN MEDICAL JOURNAL
Vol. 68, No. 5 MAY 1969

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Urge Senate Passage of Medical Education Bill

INCLUDES CREATION OF MED. ED. COUNCIL

A major medical education bill in the Wisconsin Senate has been recommended for passage by the Senate Committee on Taxation, Banking, and Insurance.

It has been referred to the Joint Finance Committee.

The Bill (283.S.) is designed to increase the number of students entering Marquette School of Medicine each year, with state financial support; expand the entering enrollment at the UW Medical School to 160 students as soon as feasible; create a new medical school of at least 100 students per class as soon as possible; and develop pilot postgraduate medical education programs for physicians and allied health professionals.

Twenty-two senators have joined in offering the bill. They are Senators Lorge, Bear Creek; Johnson, Eau Claire; Draheim, Neenah; Soik, Whitefish Bay; Lourigan, Kenosha; Heinzen, Marshfield; Knutson, La Crosse; Schneeberg, Brown Deer; McParland, Cudahy; Roseleip, Darlington; Meunier, Sturgeon Bay; Whittow, Milwaukee; Terry, Baraboo; Krueger, Merrill; Lotto, Green Bay; Cirilli, Superior; Busby, Milwaukee; LaFave, Oconto; Hollander, Rosendale; Devitt, Greenfield; Chilsen, Wausau, and Rasmusen, Spooner.

To accomplish its purposes the bill would levy a tax on cigarettes.

Among the provisions of the bill is the creation of a Medical Education Council. It would consist of the deans of the state's two existing medical schools, the dean of a third yet-to-be-created school, the state health officer, and a representative of the state medical society.

Tax revenues would be channeled to a special nonlapsible trust fund designated as the medical education fund.

The fund would be used to "improve the quality of education of physicians and allied health professionals, including the establishment and the maintenance of programs in the field of family medicine.

"It would also be used to fund programs designed to increase the number of physicians and individuals in allied health professions practicing in Wisconsin."

The assets of the fund are intended to be used to "pay for the construction of medical educational facilities, whether financed on a cash basis, with borrowed funds, or on a lease–rental basis."

Location of a medical school would be established by the board of regents of the University of Wisconsin with approval of the state building commission.

Hold Medical Career Day

MEDICAL CAREER DAY—Nearly 500 high school students from around the state attended the Medical Career Day April 19 in Madison. The program was sponsored by the State Medical Society's Auxiliary. Students toured the University Hospitals and the Society headquarters and had a choice of attending one of two medical career seminars. Students are shown above in the Presidents Room of the Society "home."

Doctors Intensify Efforts for Areawide CHP

Areawide comprehensive health planning is in the discussion stage in many areas of Wisconsin. But only the Milwaukee and Madison area programs have been funded.

Most view the "talking" stage as critical to proper development of the new programs inspired by Public Law 89–749. In fact, there is some fear of premature funding—before the local participants are ready.

The Fond du Lac County Medical Society, under the presidency of Dr. John G. Parrish, is giving initial impetus to areawide planning in that area. Recently, an 8-member resource committee was appointed at a meeting of some 50 representatives of the medical profession, government, health services, and the public. The purpose of the committee is to "establish lines of communication" between those involved in health planning.

In central Wisconsin, the Marathon County Medical Society has endorsed a proposal of the Wausau Area Health Facilities Planning Council which urges "immediate cooperation and collaboration between the boards of directors of the hospitals in the county." At the same time, the county society agreed to support the basic concept of health facilities planning in the area.

The Sheboygan County Medical Society has voted to join the Northeastern Wisconsin Community Health Committee which is pressing for comprehensive health planning in Brown, Kewaunee, Door, Oconto, Shawano, Menominee, and Manitowoc counties.

Marinette county also may join the Northeastern group, bringing to nine the number of counties involved there.

Dr. John Dettmann, Green Bay, has been elected temporary chairman of the Northeastern group. He explained that "areawide health planning is not an option but a requirement of the 1966 federal law passed along with Medicare and Medicaid.

THE FOND DU LAC COUNTY MEDICAL SOCIETY recently called a meeting of 50 county residents at the Wisconsin State University–Fond du Lac Campus to discuss areawide comprehensive health planning. Leaders of the discussion are shown above, standing, left to right: Dr. Norman O. Becker, Dr. John G. Parrish, Jr., Dr. Robert Cullen, and Dr. David J. Twohig, Jr., all of Fond du Lac; and seated, left to right: Gerry Halverson and Vincent F. Otis of Madison and Dr. Robert Carlovsky of Fond du Lac. Doctor Parrish is president of the Fond du Lac County Medical Society. Halverson is a planner and Otis is deputy director of the State Bureau of Comprehensive Health Planning. (Photo courtesy FOND DU LAC COMMONWEALTH REPORTER)

"At this stage," he said, "joining an area council is voluntary, but if a county doesn't, at some stage it will be assigned."

The Dodge County Medical Society is taking leadership in providing information for citizens of that county and the area. Recently it hosted meetings with representatives of the Dane County Health Planning Council and the Winnebago County Medical Society Areawide Planning Committee.

Dr. Robert Urbanek, Beaver Dam, heads the Dodge County Area Planning Committee. He considers Dodge county a "swing county" in the formation of areawide agencies. He explains that it could become part of the Dane County area, or join the Fox River Valley group which is proposed to include Outagamie, Winnebago, Green Lake, Waushara, Waupaca, and Fond du Lac counties, or it could become part of a smaller area with adjacent counties to the north and west.

In southeastern Wisconsin, Kenosha, Racine and Walworth are considering whether to join the Milwaukee Area Planning group.

Throughout the state, the current effort is to develop multi-county relationships which are "compatible and congenial," as one physician put it. Such inter-county contacts are essential for successful joining of planning activity.

SK&F Film: Infant Addiction

A 16 mm color movie called "Recognition of Narcotic Withdrawal Symptoms in Newborn Infants" may be obtained by physicians through Smith Kline & French's Professional Service Representatives, or by writing directly to SK&F at 1500 Spring Garden Street, Philadelphia, Pa. 19101.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others.

Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1969 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

THE DODGE COUNTY MEDICAL SOCIETY recently met in Beaver Dam for discussion of areawide comprehensive health planning. Directing the discussion were those shown above, standing, left to right: Robert Dott, Beaver Dam, member of the Dodge County CHP committee's executive committee; Eric Jacobson, regional representative of the State Medical Society; and Dr. Roger Bender, Beaver Dam, president of the Dodge County Medical Society; and seated, left to right: Dr. Paul Godes, Neenah, chairman of the Winnebago County Medical Society's areawide planning committee; Dr. Robert Urbanek, Beaver Dam, chairman of the Dodge County CHP committee; and Gregory Griffin, Madison, executive director of the Dane County Health Planning Council, Inc. (Photo courtesy BEAVER DAM REPORTER)

Survey Stimulates Return of Therapists to Employment, Easing Manpower Shortage

A recent survey of occupational therapists in Wisconsin revealed 581 persons engaged in this activity in the state.

Analysis of the results surprised no one—there is a need for more trained occupational therapists.

But some of the facts discovered are interesting. For example, only about 49% of the registered occupational therapists in Wisconsin are employed. The remainder, 51%, were not employed at the time of the survey.

Replies from certified occupational therapy assistants showed 89% employed and 11% unemployed at the time.

OTRs are employed in 23 of the state's 72 counties, but there are only 57 practicing OTRs outside Milwaukee and Dane counties. Confirming everyone's suspicion, 98% of the OTRs are female.

COTAs are employed in 35 of the 72 counties, and 93% are female.

As a result of the survey, intensive efforts have been made to recruit the nonemployed occupational therapists. The results have been good . . . at least 50 therapists have agreed to go back to work, either full or part time.

The Wisconsin Occupational Therapy Association, which did the survey, now has established refresher courses aimed at recapturing even more of this short-supply manpower.

WPS Issues Brochure on Claims Reporting

Persons who have both Medicare and the WPS supplementary program, known as "Medicare-PLUS-$15,000," can get special help from a WPS prepared brochure designed to answer their questions about filing claims.

Entitled "How to File Medicare-PLUS-$15,000 Claims," this brochure has large, easy-to-read print, simple diagrams, and everyday language to explain claims filing procedures for both Medicare and the WPS plan.

Physicians and their office assistants will find the booklet helpful for their over-65 patients.

Copies may be obtained by writing WPS, Box 1109, Madison, Wis. 53701.

Brochure: The Salk Institute

A descriptive brochure which outlines the purposes, goals, and activities of The Salk Institute is available upon request to The Salk Institute, P.O. Box 1809, San Diego, Calif. 92112.

State's Schools to Upgrade Health Teaching

Teachers of health education in the state's schools will be subject to new requirements starting in the fall of 1969.

Teachers of health will be required to have at least a 22 credit minor in health education in order to be certified. This is the same requirement for subject certification now applied to all other teachers.

Those teachers of health who have not completed a health minor may obtain temporary certification (one-year special licenses) by completing six semester hours of course work acceptable to an institution offering an approved health education minor.

The State Department of Public Instruction has stated that refresher courses in health education are desirable if a minor was completed five or more years ago.

The State Medical Society's division on school health is currently seeking support to help the Department establish a new curriculum program in health education.

Alcoholics and Alcoholism

A new Public Affairs Pamphlet by Harry Milt. Concise summary of what is known today about alcoholic addiction and its victims; about various kinds of treatment and the chance for cure; and the organizations that are helping.

This pamphlet, No. 426, is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

Dr. Falk Serves Volunteer Duty in Nicaragua

Some doctors would rather spend their vacation rendering medical aid to people in other lands. This therapeutic work can be just as relaxing as a trip to the north woods or to the sunny south.

Dr. V. S. Falk and his wife, Rae, spent the month of February in Nicaragua where they offered their services.

Doctor Falk's trip was arranged by the Alliance for Progress in which Wisconsin and Nicaragua are designated as sister states.

There has been considerable interchange between Wisconsin and Nicaragua in the last few years particularly in the fields of education, agriculture, and medicine.

(Doctor Falk previously served two 60-day tours of voluntary duty in Viet Nam.)

The following report by Doctor Falk indicates the rewarding experience of the trip.

* * *

"Nicaragua, largest of the Central American countries, is about the size of the state of Illinois and has a population of less than two million.

"We were located at Bluefields on the East coast. The population there is about 12,000 and is a thoroughly integrated mixture of Spanish, English, Mosquito Indians, and Jamaican blacks.

"When we arrived at Bluefields, we were told that this was a mañana town and the slogan was, 'Never hurry—never worry.'

"My mission was to work along with local doctors who would observe my techniques and methods in anticipation of improving their services. Abdominal surgeries, especially for hepatitis, were urgently needed.

Four-Building Hospital

"Hospital San Pablo, with 150 beds, consisted of four separate wooden buildings. The general wards were in the main building and here the patients paid nothing. In 'Pension' the rates were from $3.00 to $7.00 a day for private rooms, but the more expensive rooms were rarely occupied.

"In another section called New House (which was really a misnomer for a 40-year-old, barn-like structure) there were innumerable old men who received very limited medical attention. Tuberculosis patients were also in a separate building and apparently no doctor ever went there.

"On my first trip into the hospital operating room, I was impressed first by the air conditioner, next by the piped-in Spanish music, then by the surgeon wearing dark glasses, and by the assistant scrub nurses wearing uniforms made of flour sacks.

"At the conclusion of the operation the nurse, who also was first assistant, did the skin closure.

DURING THEIR VISIT IN NICARAGUA, Dr. and Mrs. V. S. Falk visited with the vice-president of the Wisconsin–Nicaragua Partnership Alliance, Dr. Jose Canton (left); the vice-president and minister of health, Dr. Francisco Maliano (third from left); and two other doctors who are members of the ministry of health (on the right).

"The nurse anesthetist used Pentothal for induction, followed by either ether or Halothane in a closed system. Intubations were done quite routinely, although always through the mouth, as I learned to my sorrow when I was about to do a tonsillectomy.

"The surgical schedule was generally quite heavy and the most common procedures were herniorrhaphies and gynecological operations, particularly hysterectomies.

"I did several thyroidectomies and was surprised to find these nontoxic goiters in a seacoast area. Machete wounds were very common.

"One unusual, although minor case, was the removal of a large beef fly larva from the eye of a young boy.

"Inguinal hernias were extremely common and usually bilateral. Direct hernias seemed to occur in unusual disproportion.

Recommendations Made

"Indwelling catheters were routinely inserted in all surgical patients, even once for a thyroidectomy. Small blood transfusions (200–300 cc) were given postoperatively to almost all patients—even appendectomies and herniorrhaphies. These situations were among the changes that I suggested in my list of recommendations just before I left.

"At every operation I was assisted by a Bluefields physician. Often others would observe along with an interpreter to explain the procedure.

"Anemia and malnutrition were very common. Hemoglobin levels of 20% were common in the pediatrics ward.

"The hospital had no laboratory but there was a technician across the street in a separate government facility.

"The hospital had a small and very limited blood bank. Life expectancy in Nicaragua is about 50 years, compared with 34 in Viet Nam and 70 in the United States.

Throughout the country most of the deliveries are performed in homes by mid-wives. The mid-wives

use Pitocin indiscriminately, often giving from 10 to 30 units early in a labor when there is almost no dilatation.

"In the workroom adjacent to surgery there were three autoclaves. The smallest of these was fired with gasoline and was the only one in use. The other two large autoclaves had been sent down from the States and required steam, but no steam was available. Consequently, these two large autoclaves were used for storage. Also, a large x-ray unit that had been shipped down from the States, could not be used because there was no transformer.

"Rae worked with the sisters (a Capuchin Order originating in Spain) to establish a simple medical record library—and extracted a promise of an office addition to house it. She also catalogued all of the hospital library books in such divergent fields as medicine, nursing and religion—and all in Spanish!

A Pleasant Experience

"We stayed in a private home and our food there was interesting and good.

"Initially, there was some question among the seven local physicians as to just what my mission was there, but after a few days there was excellent cooperation.

"As confidence developed, the surgical patients included nurses, nuns, and relatives of the doctors and nuns.

"At the end of my stay, the Medical Staff indicated that they were pleased because this was the first time that anybody from the United States had ever come there and actually done any work. Others had come there to talk and fiesta but never actually to work.

"On our return to Managua we met the Vice President of Nicaragua who also was the Minister of Health. Our interview was cordial but somewhat hampered by the fact that he spoke no English and we spoke no Spanish.

"Incidentally, the President of Nicaragua is a graduate of the United States Military Academy at West Point. Although we did not meet him, President Somoza sent us a warm, lengthy telegram at the conclusion of our stay."

Interested in a Working Vacation Abroad?

A few of the major organizations sponsoring volunteer physicians abroad are listed here for the benefit of Wisconsin physicians wishing to spend vacations in a similar manner as Doctor Falk. Interested physicians should contact directly the sponsoring organization of his choice for further information.

Volunteer Physicians for Vietnam: Sponsored by the American Medical Association, the program is designed to relieve civilian suffering in a country possessing a severe shortage of medical manpower. Finances come from the United States Agency for International Development (USAID).

Physicians serve two months without pay in Vietnamese civilian hospitals. Transportation is provided to and from the physician's Vietnamese destination, and housing is provided. Each volunteer physician receives a minimal expense allowance; and expenses connected with passport, visa, and immunization are paid by USAID.

Dr. Charles H. Moseley, Director, 535 N. Dearborn St., Chicago, Ill. 60610.

Project HOPE: Project HOPE (Health Opportunity for People Everywhere) is the principal activity of The People-to-People Health Foundation, Inc. of Washington, D.C., an independent, nonprofit corporation. Its principal objective is to teach medical, dental, and paramedical personnel in developing countries the latest techniques of US medical science.

Training is conducted on the hospital ship, SS HOPE, which docks for a year's stay per country. Countries who have been aided are Indonesia, South Vietnam, Peru, Ecuador, Guinea, Nicaragua, Colombia, and Ceylon.

Volunteer teams of physicians, surgeons, and dentists in 20 specialties are flown to the ship for two-months service without pay. HOPE teams throughout the host country examine patients, sending to the ship for hospital care the cases which are most urgent or medically instructive.

Upon request of a host country HOPE selects a nucleus of medical personnel to remain behind when the ship leaves. Teams of up to 20 or more physicians, dentists, nurses, and technologists follow up on teaching programs instituted during the ship's stay.

The People-to-People Health Foundation, Inc., 2233 Wisconsin Ave., Washington, D.C. 20007.

AmDoc: AmDoc (short for AMerican DOCtor) is a nonprofit, nonsectarian, nongovernmental related corporation. It places physicians into suitable needy locations in countries outside the US. Hospitals and clinics are now established in Central America, South America, the Far East, Southeast Asia, the Near East, and Africa. An intermediary between the haves and have nots, AmDoc seeks to render medical service without fanfare but with precision.

American physicians volunteer for one month or longer, and they finance the trips themselves. On the average, the cost to the physician is about $300. Physicians serve with a team at a hospital, a mission, an improvised clinic, or an outlying medical field station.

AmDoc, Inc., 27 E. Cannon Perdido St., Santa Barbara, Calif. 93101.

LAOS: LAOS (Laymen's Overseas Service, Inc.) is a nondenominational organization that recruits and trains short-term, self-supporting volunteers for various services in Latin America, Asia, and Africa, and the United States.

Usually physicians pay for their food, while the local hospital or church supplies housing. Families are welcomed to participate.

LAOS, Inc., P.O. Box 5031, Jackson, Miss. 39216.

FOCUS, Inc.: Volunteer ophthalmologists may elect to serve with FOCUS, Inc. (Foreign Ophthalmological Care from US), a nonprofit and nonsectarian agency for establishment and maintenance of eye departments in Haiti. Haitians supply room, board, and internal transportation. Procurement of drugs, medicine and glasses, and the recruiting of physicians are assumed by FOCUS, Inc. Generally, FOCUS buys a volunteer's tickets to Port au Prince, but each volunteer is expected to contribute to FOCUS an amount to cover this cost.

Physicians are asked to serve for a month. They may return for additional tours of duty. Expenses will also be paid for the physician's wife if she wishes to serve.

FOCUS, Inc., 1431 Ashland Ave., River Forest, Ill. 60305.

Project Concern: This nonprofit organization, founded by Dr. James W. Turpin, seeks to bring medical care to the world's needy of all ages. Currently, the organization has operations in Hong Kong, South Vietnam, and Mexico and has an international staff of more than 137 doctors, nurses, pharmacists, laboratory technicians, teachers, x-ray technicians, and supporting staff.

Project Concern's current projects include outpatient and mobile clinics, self-help training programs, and mother-and-child care centers.

Project Concern, Inc., P.O. Box 2468, San Diego, Calif. 92112.

Museum Opened April 15 Despite Flood Waters

The Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien opened April 15 on schedule despite flood waters "lapping at the doors."

Gordon Peckham, museum curator, reported the "only casualty was a wet children's sandbox on part of the lower lawn" at the Beaumont street location.

The national historic site, visited by thousands each year, is open daily from April 15 to November 1.

The Museum is the only remaining portion of the second Fort Crawford, which itself was a result of the Mississippi floods 143 years ago. The first Fort Crawford, on lower ground, was built against the Indians in the early 1800s, but surrendered instead to the Mississippi.

Flood waters inundated the log defense structure repeatedly and "dampness caused malaria and other sickness among the soldiers." The current fort was erected on higher ground in 1826.

The fortress Museum is owned and operated by the Charitable, Educational and Scientific Foundation of the State Medical Society.

School Health Guides Now in Preparation

Two new guides dealing with school health are in the process of preparation through the cooperation of the Division on School Health of the State Medical Society.

The first is a revision of the highly popular School Health Examination Guide. The new edition will feature added material on immunizations, health observation, hearing screening testing, health exams for school employes, and athletic examinations for both male and female students.

It is anticipated that the guide will be made available to all schools and school districts.

The second publication is one developed by the Division of Health of the State Department of Health and Social Services to deal with health emergencies in the school. The Society's division on school health has made a number of recommendations concerning the booklet.

WPS Offers Drug Education Literature, Films

Drug education materials are in great demand these days as a result of widespread publicity to drug abuse, especially among teenagers.

Recognizing that physicians and others have need for authoritative information on these subjects the State Medical Society and its WPS health insurance division are making available several tools for drug education.

The following materials are available upon request to the State Medical Society, Box 1109, Madison, Wis. 53701:

Brochures: "Glue Sniffing," "Marihuana," "LSD," "Barbiturates," "Amphetamines," and "Drug Abuse: The Chemical Cop-out."

Films: "LSD and Other Many Splendered Things," "How to Kick the Habit" (1½ hours), and "Should You Keep Off (Or ON) the Grass?", "Sex and the Teenager," "Smoking and Other Burning Issues," and "The Tappa Kegga Da Fraternity."

"PILOT HEALTH SURVEY" LAUNCHED IN CHIPPEWA

A "pilot health survey" has been launched in Delmar Township in Chippewa County as part of a federally funded West Central Wisconsin Community Action program.

Under the title "Rural Health Service," the project is to "provide stimulation and incentives to communities and to individuals to improve the level of health, to offer emergency assistance for medical care to economically deprived persons, to give assistance with medical and dental care to raise the level of health."

The Action organization is headed by J. C. Banks, Menominee, and serves a seven-county area. He states the program is designed to "serve new needs, not to duplicate services."

Mr. Banks states that when the study is completed its results will be available to the Chippewa County Medical Society and to interested community leaders.

Placement Service Available

The Society's Placement Service has registered with it a number of physician openings. Contact the PS at Box 1109, Madison 53701, or phone 608/257-6781.

SMS Hot Line

U.W. MEDICAL SCHOOL EXPANSION . . . has received a boost from the Joint Finance Committee of the State Legislature. It is recommending to both houses of the Legislature (as part of a revamped budget bill) that $1,310,000 be appropriated for UW medical school facility planning. Three "conditions" are part of the recommendation:

A. That the planning be done for a site near the VA hospital in Madison.
B. That Phase I of construction be limited to $50,000,000 . . . this would not include equipment and furnishings.
C. 50% federal matching is assumed.

It appears to be the intent that the planning grant is contingent upon these conditions being met, and construction could not go forward if the federal matching requirement was not met.

CHIROPRACTORS DRIVE ON HOSPITALS . . .

The Palm Beach Times

WEST PALM BEACH, FLORIDA, FRIDAY AFTERNOON, MARCH 21, 1969 —D1

Chiropractors Complain Of Hospital Treatment

VERO BEACH — Dr. George Fika of Vero Beach charged Thursday that he and other area chiropractors are being discriminated against by Indian River Memorial Hospital.

He told the hospital's Board of Trustees that chiropractors are now allowed to study or take out X-rays of their patients at the hospital.

Dr. Fika was represented at the board meeting by attorney L. B. Vocelle, who requested that X-rays be released to duly licensed chiropractors for purpose of diagnosis.

Board Chairman Joe Earman said that according to the hospital's by-laws, reports and X-rays can only be released to physicians and surgeons practicing medicine in the United States.

"All records are property of the hospital and can only be released by court order," Earman said.

Vocelle, however, said that under Florida law all medical professions, including chiropractors, are authorized to do business in the state. He said chiropractors are authorized under law to use X-rays.

"Therefore," said Vocelle, "I am making two requests — first, that this board grant Dr. Fika, and his colleagues in the profession, the same privileges as the other physicians who have patients in this hospital — and use no discriminatory actions against them; and second —that they be allowed to use the X-ray facilities in his hospital and be allowed to have the X-rays released to them."

Earman referred the matter to the joint conference committee who will meet with the executive committee of the medical staff to discuss this matter and report back to the board.

Wisconsin next?

THE 1969 WORK WEEK OF HEALTH . . . is scheduled for October 6-10. High school students and teachers will be invited to regional meetings on Drugs and Sex and the Teenager . . . meeting centers will be in Eau Claire, Wausau, Green Bay, Milwaukee, and Madison.

Statewide Interest Mounts for Drug and Sex Education

Drug education programs for students, teachers, and parents are enjoying unprecedented popularity in the state since the 6th Annual Wisconsin Work Week of Health, sponsored by the State Medical Society last fall.

Under the title "Youth on a Four-Day Trip," the Society attracted over-flow crowds to hear discussions on marijuana, LSD, alcohol, and other drugs.

The drug presentations were recorded on both audio and video tape. Under a public service grant from Wisconsin Blue Shield (WPS), the audio tapes and 16mm films on drugs and sex education have been made available to the state's high schools and civic groups.

Already more than 1,800 showing requests have been received by WPS-Blue Shield. The films are booked almost solidly from now until well into the fall school term in 1969. Requests are coming from throughout the nation as publicity has reached beyond the borders of the state.

Meanwhile, the Work Week program and the films have stimulated local efforts to duplicate the program in part in high schools across the state.

The Madison Attic Angel Association, with cooperation from many groups, in April sponsored a three-day, in-school drug education program in Madison's five high schools. Three teams of youthful ex-addicts, presented programs at each school. An evening "open forum" on WHA–TV (Channel 21) took the educational effort directly to the community.

A similar effort, using ex-addicts from Encounter, Inc. in New York City, was employed in the Waukesha high schools in cooperation with the Waukesha County Medical Society. Other county medical societies throughout the state have also worked with such programs using local physicians and printed materials supplied by WPS-Blue Shield.

At the same time, WHA–TV has televised the entire Work Week of Health series of eight programs on two separate week-long evening schedules. Some programs have been televised three times because of demand.

The State Medical Society plans to take the 1969 Work Week of Health on a tour of Wisconsin with outstanding speakers on drugs and sex education being made available to regional audiences during the first week of October.

"Meet the Press" Conference

Junior and senior high schools in Madison and Dane County sent representatives to a "Meet the Press" conference recently at University Hospitals. Dr. R. Samp* and a panel of medical researchers and specialists discussed the problem of smoking and its relationship to diseases. The conference was sponsored by the school education committee of the American Cancer Society, Dane County Unit.

Dr. W. P. Curran Honored by PACE

At a staff meeting of the Langlade County Memorial Hospital in Antigo April 8 Dr. William P. Curran (right) of Antigo was presented a plaque on behalf of his interest in better government and in recognition for his efforts as one of the founding members of PACE—Professional Association for Civic Education.

The presentation was made by Dr. E. P. Ludwig of Wausau, seventh district councilor, on behalf of members of the PACE board of directors. (Photo courtesy ANTIGO DAILY JOURNAL)

Workmen's Comp. Claims Increase on Industry-related Mental States

Mental illness and emotional reaction are rapidly increasing as factors in workmen's compensation claims, according to Edward E. Estkowski, Madison, Commissioner of the Department of Industry, Labor and Human Relations for the State of Wisconsin.

"Either the number of cases is increasing or the employer is becoming more aware of the possibility of industrial origin of mental disturbances," he said. "Or it could be that more employers are alert to the possibility of stopping accidents before they occur, and are seeing that the employe receives treatment before he injures himself or a fellow worker."

The Commissioner says that "we feel, but can't prove, that emotional tensions and anxiety cause distractions which lead directly to accidents and work injuries."

The Wisconsin department is making plans for special studies by the University of Wisconsin psychology department to uncover the "psychological reasons for accidents."

Estkowski believes that company mental health programs are one answer to the problem. "I suppose the most acceptable program might be that in which the doctors are given a free hand in administering the program. If the workers know that only the doctor is making the decision, perhaps they would accept these services."

"In smaller companies, the lack of medical or safety staff need not be a deterrent," Estkowski said. "The first line supervisor should be able to spot potential and actual mental health problems just through his normal relationship with all employes. The important thing here is for management to arrange a referral system."

THE NEW PRESIDENT

ROBERT E. CALLAN, M.D.

A MILWAUKEE PHYSICIAN is the new president of the State Medical Society of Wisconsin. Dr. Robert Edward Callan, who for six years directed the affairs of the House of Delegates as its speaker, assumed his new duties at the Society's 128th annual meeting this month. ■ Doctor Callan was born Sept. 22, 1915, in Milwaukee where he graduated from Marquette University High School. He attended the University of Wisconsin in Madison for his premedical studies. In 1942 he graduated from Marquette University School of Medicine. ■ Following an internship at St. Louis University Hospital Group, Doctor Callan served as Medical Officer in the Air Corps during World War II. He served overseas in Italy. ■ Doctor Callan has been in private general practice in Milwaukee since 1946. Since that date also he has been an aviation medical examiner for the Federal Aviation Agency. Doctor Callan serves on the medical staffs of five Milwaukee hospitals: St. Mary's, Misericordia, St. Anthony, Milwaukee County General, and Sacred Heart Rehabilitation. He also is a past president of Misericordia Hospital's medical staff. ■ An active participant in medical society affairs, Doctor Callan has served on numerous committees of The Medical Society of Milwaukee County and the State Medical Society. He is a past president of the Wisconsin Academy of General Practice and a former delegate to the American Academy of General Practice. ■ Doctor Callan presently is a member of the Planning Committee of the Wisconsin Regional Medical Program, Inc. and the Health Services and Needs Technical Committee of the Advisory Council for Comprehensive Health Planning. He also is an instructor in the Department of Environmental and Occupational Medicine of Marquette School of Medicine. ■ Doctor and Mrs. Callan, the former Mary E. Phelan, reside in Wauwatosa with their four children. Mrs. Callan is a sister of Dr. John T. Phelan, a well known Marquette graduate.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Editor's Note:

Almost as dismaying as the deficiency in medical care of the aged is a prevalent lack of concern about their dental care. A preliminary report of a recent limited survey by the Wisconsin State Dental Society indicated virtual absence of any sort of systematic program of dental hygiene in many homes for the elderly, and widespread urgent need for dental treatment among the residents. Dr. Fred R. Salerno, Chairman of the Department of Community Health of Marquette University School of Dentistry, was invited to comment on the physician's concern in geriodontics. Educated at Tufts, Harvard, and West Virginia, Doctor Salerno took time out from practicing his specialty of endodontics to earn a Master's degree in Public Health at the University of Minnesota. In addition to his duties as an Associate Professor at Marquette he is Visiting Professor to the School of Nursing at UW–M where he teaches Community Health. He has published numerous papers on endodontics and various aspects of preventive dentistry. His adroit and thoughtful essay on a serious problem follows.—D. N. G.

GUEST EDITORIAL

The Physician's Role in Geriodontics

■ RETIREMENT IN HEALTH, honor and dignity are the main circumstances that a person who has reached his "golden years" wants to enjoy. The majority of these persons have devoted five-plus decades of their lives to performing, to the best of their ability, some task that in some way affects all of our lives, directly or indirectly, and made this a better world in which to live. As members of the health profession, what do we owe these people?

The number of elderly people in our population is growing rapidly, and the physicians and dentists are noticing that many of them have a better understanding of total health, including oral health, than their predecessors. A possible reason is that in their younger days their teachers, their physicians, their dentists, and the media of communication taught them how to preserve their teeth. Before long we may have a generation of older individuals who drank fluoridated water in their formative years, and they may have teeth with lifetime quality. With proper care and education, our older patients should not all be candidates for complete dentures. However, their teeth, oral soft tissues, jawbones, the muscles and skin of the face, all undergo aging changes closely related to those which affect the rest of the body and the mind.

Next to the dentists and dental hygienists, the physicians are asked more questions on oral health than anyone else by these geriodontic patients, who are "special patients" only because they find it hard or impossible to get to see a dentist. Unless the physician learns to evaluate the elderly person who brings his oral problem along with his other

problems, his reputation as the physician of total health care may be seriously challenged. It is not suggested that the physician render dental services to these elderly patients, but it is the physician's professional responsibility to see to it that he is referred to a dentist, or to get a dentist to come to his patient. If one of the physician's patients has a medical disease for which he needs consultation he does not hesitate to call in a medical specialist to examine his patient. Is it not the professional responsibility of the physician, who is the key member of the health team, to call in a dentist or refer his patient to one, especially the nonambulatory or homebound patient?

The most prevalent diseases known to man are oral diseases. Almost every person has had, has, or will have dental problems. Yet oral problems are usually not contagious or deadly. The undramatic nature of oral diseases undoubtedly contributes to the astonishing proclivity of the physician to overlook these conditions. The nondental public was conditioned to believe that edentulousness was an unavoidable concomitant of advanced years. Many people were convinced that dentistry for the elderly was limited to "grinding down their false teeth." But older individuals are no longer willing to sacrifice their teeth. Dentistry is more than plugging holes in teeth, bridging vacant spaces between teeth, or putting "plates" in empty mouths. By restoring and maintaining the oral cavity to the best condition for each person, we give these elderly patients a feeling that "someone cares," improve their health and their esthetics, and give them a better outlook on life.

The mouth is regarded as an integral part of the body entity because many oral disease or disorders are known to be correlated with a systemic morbidity. The condition in the mouth may be the cause or the effect of an abnormality in the health of the body or of the mind. The mouth is truly the "mirror of the body" in that many symptoms or diagnostic signs are first observed in the oral cavity. It is the most accessible and acceptable orifice that a physician can look into, and see further inside, without instruments. An oral cancer examination is within the realm of the physician.

The physician may not know of a dentist to whom he can refer his patient. Dentists' names can be obtained by calling the local dental society, the local health department, or the nearest dental school.

The greatest sin of maturity is losing one's zest for life. Are the physicians contributing to this loss by not treating the total health of their patients even if it is only by referring them to the proper discipline?
FRED R. SALERNO, DMD, BS, MPH, Milwaukee, Wisconsin □

A STUDENT who intends to work this summer and who does not have a social security account number card should apply for one at the social security office. □

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to : THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

HOW TO GET PAID FOR TREATING MILITARY PATIENTS

To the EDITOR:

There seems to be considerable confusion among the civilian medical profession as to where and how to bill the Army for services rendered to military personnel.

We believe the attached notice would help your readers and relieve their frustration by giving them a definite guideline for collection of their fees.

We hope you will see fit to publish it in an early edition.

JOSEPH ISRAELOFF
Chief, Technical Liaison Office
Department of the Army
Office of the Surgeon General
Washington, D. C. 20315

* * *

Payment to civilian sources for emergency professional services rendered to military personnel who are on active duty (as contrasted to retired, or inactive members of the National Guard or Reserve) is the responsibility of the Surgeon of the geographical area in which such services are provided. Collection cannot be made from the Office for the Civilian Health and Medical Program for the Uniformed Services (OCHAMPUS), Denver, Colo., or its fiscal agents, who are responsible only for the payment of medical care rendered to authorized dependents and retired military personnel.

When a patient is identified as an Army member, on active duty, notification should be made immediately by telephone to the appropriate Army headquarters, as listed below, reporting where the individual is and the nature of the treatment required. The cost of the telephone call will be reimbursed with the other charges.

The Army headquarters will advise the caller about the administrative management of the patient, and how to submit the bills for service.

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Commanding General
Fifth United States Army
ATTN: Surgeon
Fort Sheridan, Ill. 60037
Telephone Number:
Area Code 312
Weekdays: 926–3675
Nights, weekends, and holidays: 926–2238 □

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It can be obtained from Translation Company of America, 500 Fifth Avenue, New York, N.Y. 10036. □

Drug Literature and the Hospital Library

By ELIZABETH MACNAUGHTON, Madison, Wisconsin

■ THE DRUG EXPLOSION is only one attribute of the continuing "information explosion," but it is one about which the biomedical community has particular reason to be concerned. The number of new pharmaceutical products introduced in the United States over the ten-year period 1959 to 1967 was a substantial 2131; added to this was a total of 656 new dosage forms, for a grand total of 2787 new U. S. products.[1] This output in itself is impressive, but one feels rather cautious in expressing enthusiasm when one learns that only about 15 percent of these new products have been rated as "important new single entities."[2] Experimental drugs form a separate category which numerically is almost as considerable as the newly marketed group. The number of Investigational New Drug applications filed with the Food and Drug Administration is about 2000 yearly.[3] These numbers reflect an enormous investment in drug research activities being carried out by both the drug industry and the Federal government at the rate of nearly $600 million per year.[4]

These facts and their implications pose a number of communications and informational problems for all members of the medical profession. New drugs, new varieties of older substances, different product combinations and new dosage forms are continually parading onto the scene. Any one product may be described by a number of labels—proprietary (brand, trademarked) name, generic (nonproprietary, nonchemical) name, chemical name or code number. The researcher needs to be in contact with information concerning such new drugs or investigational drugs, and biochemical developments in very minutely delineated areas. The practicing physician—the drug prescriber—needs unbiased, objective clinical evaluations of new drugs, as well as an awareness of new dosage forms. He is the recipient of a continual barrage of promotional literature from the mail, from the detail man, and from journal advertisements. Although these sources of information have their value, they lack the desired objectivity. Added to this problem is the fact that a wide variety of other health-related professionals—chemists, biophysicists, pharmacologists, pharmacists, drug manufacturers, nurses—all have their own individual and very different kinds of expectations from published information on any one drug or type of drug. This information may be found in books, periodicals, patents, government publications, compendia, alerting services, and secondary sources such as indexes, abstracting services, book reviews, and some of the newer, mostly computer-oriented, tools such as *Current Contents* and *Index Chemicus*.

Mrs. Macnaughton is Reference Librarian, Middleton Medical Library, University of Wisconsin Medical Center.

In 1963, the National Library of Medicine published *A Factual Survey on "The Nature and Magnitude of Drug Literature."* While some of the facts that this study presents are already obsolete, it remains the most definitive statement on the extent of the drug literature problem to date. From its description of the wide variety of printed matter dealing with drugs, one is ultimately made aware of the fact that access to the journal literature is the most vital key to the conundrum. The study states:

> ". . . 200,000 articles (1963 estimate) probably remain a reasonable working figure for the number of pharmaceutical papers appearing annually."[5]

The "World List of Pharmacy Periodicals" which appears as Appendix C to the report lists some 911 journals, of which 650 were currently (1963) being published. This list excludes all clinical journals on one hand, and journals dealing exclusively with chemistry on the other. Another "Composite List of Journals of Pharmaceutical Interest" (Appendix D) lists another 726 journals, of which 344 titles do not appear on the "World List." Figures given in Section 9 of the report suggest that there is a considerable number of journals not appearing on either list! Moreover, the scope of drug literature on any one drug is international, and often may cover a substantial period of time.

Where can the physician turn then for rational and unbiased judgments on drugs, if indeed, his impulse is not to turn away from a seemingly disorganized welter of facts in utter confusion? He may depend upon his own reading of a few journals to "keep current" but it is easily demonstrated that this approach would be inadequate for a "literature search" on any one drug. There are other techniques for keeping up-to-date which may be employed, such as journal clubs, personal contact with colleagues or pharmacists, or radio/telephone conferences. Since various surveys have shown that journal reading stands above the rest as the preferred mode for continuing self-education, the problem, for the most part, boils down to how to provide the physician with the widest possible scope of such literature in the shortest possible period of time. The hospital or clinic library is usually the most immediate (but also most often overlooked) resource of this nature near at hand.

A hospital or clinic library, however, even if well equipped, cannot afford to maintain the hundreds of journals which constitute the relevant drug literature. While it is within the budgetary means of most medium-sized libraries to maintain "secondary access" tools such as *Index Medicus* and *International Pharmaceutical Abstracts*, the two other major tools for comprehensive coverage, *Chemical Abstracts*,

and *Biological Abstracts* are simply too expensive for the smaller library to buy. Also, the smaller library may find it financially burdensome to keep a large number of reference books, many of which constantly appear in new editions. But if the library is staffed by a knowledgeable person who is aware of various information pools beyond her own immediate domain, then the library can function effectively, as it should, as a starting point for further referrals into the hospital, the community, and beyond.

On the most immediate level, the librarian in a hospital may seek one solution to a wider coverage of information by establishing some form of liaison with the hospital pharmacy. The pharmacy should be well stocked with a good number of up-to-date reference books and journals to which the diplomatic librarian may gain access. Probably the most concrete and lasting form of liaison between the library and the pharmacy would be to have the books and journals in the pharmacy cataloged and listed in the library's card catalog. Thus the librarian puts herself in a position to be of potentially greater service, using resources at the local level.

The librarian's next outside resource for loans, photocopies, and more in-depth reference services is the closest regional medical library. In Wisconsin, the librarian's avenue of approach is through the Middleton Medical Library in Madison or the Marquette Medical–Dental Library in Milwaukee. In addition, the drug information pharmacist at the University Hospitals in Madison is very willing to cooperate with Wisconsin medical personnel who are in need of drug information of an evaluative nature. The succeeding avenues of recourse for the librarian in this area are the Midwest Regional Medical Library at the John Crerar Library in Chicago; and finally the National Library of Medicine in Bethesda. Usually requests for literature in the original or photocopied form can be supplied within a week.

The librarian who can function as something more than a custodian of books or a procurer of prespecified reading materials must also assume (among a large number of other professional functions) the role of a drug literature specialist, as distinct from another fairly new entity in the communications field, the drug information specialist. The distinction between these two is explained:

> "Fundamentally the drug **information** specialist is one whose education and training in the physical and biological sciences give him an intimate knowledge of drugs."[6]

As such, his functions are primarily evaluative, and he is most likely to be a person with a pharmacy degree. On the other hand,

> "The drug **literature** specialist . . . has the principal functions of accumulating, organizing, and expediting access to the documents which constitute the published record of clinical drug research. He increases the efficiency and usefulness of the person whom Franke has called the 'drug information specialist' by providing demand literature searches, bibliographic compilations, computer-processed information retrieval services and **other medical librarian functions** (bold face mine)."[7]

The Task Force on Prescription Drugs of the Department of Health, Education and Welfare in its *Second Interim Report and Recommendations* issued in 1968 makes a number of interesting observations on the state of the drug industry and its multifarious relationships with the consumer, the middleman-pharmacist, and the prescriber-physician. Of the physician, adrift on the changing tides of drugs and the ever-increasing floods of drug information, the Task Force remarks:

> "We find that few practicing physicians seem inclined to voice any question of their competency in this field. We have noted, however, that the ability of an individual physician to make sound judgments under these quite confusing conditions is now a matter of serious concern to leading clinicians, scientists, and medical educators."[8]

Among the various remedies they have proposed or recognized are sounder grounding in pharmacological principles at the medical school (grass roots) level, liaison with the drug information specialist, closed circuit television programs, and so on.

I find it remarkable that nowhere in the report is the library or the library information system which exists in the U. S. today mentioned as a viable solution to at least part of the problem of continuing education in the field of "rational prescribing." Perhaps the library as a tool for self-education is ignored because of its supposed or real ineffectiveness; or perhaps its presence is simply taken for granted. Actually, the Medical Library community, especially at the regional and national levels, is very much involved in upgrading the effectiveness of its services. These services, when used in conjunction with the others referred to above, can provide effective drug education, at the community and hospital levels.

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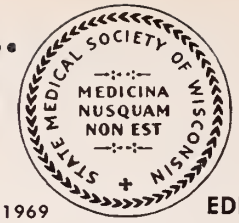
SECTION



OPHTHALMOLOGY

MAY 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

SYPHILIS AND THE EYE

By WALTER E. GAGER, M.D., Milwaukee

RECENT INVESTIGATIVE EFFORTS by prominent scientists in locations all over the world have prompted a new look at the relationship of T. pallidum, the causative agent of syphilis, to the human eye. Authoritative ophthalmological works have long associated syphilis with ocular pathology. Specifically, interstitial keratitis and uveitis are considered pathognomonic ocular features of congenital syphilis. Furthermore, central nervous system syphilis is reflected in the eye by papilledema, visual field defects, blindness and involvement of the cranial nerves manifested by extraocular muscle palsies.

With the advent of the penicillins during the second world war, syphilis was considered treatable. It was thought, and justifiably so, that an adequate dose of the new antibiotic would cure the disease. The only remaining problem was epidemiological.

T. pallidum has resisted all efforts to be grown in a laboratory environment outside of a living host. Little is known of its metabolism, reproduction, complete life cycle, and relationship with other spiral organisms causing human and animal diseases today. To date, no evidence has been offered to suggest that T. pallidum has developed a resistance to penicillin. There has, however, been data published that documents the persistence of T. pallidum in tissues *after* the administration of what was considered adequate penicillin therapy. It is this startling revelation that has prompted new emphasis on research concerning syphilis and the eye.

In 1964, Collart reported the persistence of T. pallidum in human and animal tissues after administration of adequate doses of penicillin. In 1966, Smith reported finding spiral organisms in the ocular fluid of syphilitic patients before and also after penicillin therapy. Shortly thereafter his findings were confirmed at a number of other medical centers. Most of the patients studied had: (1) history of congenital or acquired syphilis, (2) clinical signs and symptoms consistent with late syphilitic disease, or (3) serologic evidence of past infection. Ocular and central nervous system symptoms consistent with long-standing syphilis were present but the eyes were white and quiet with no sign of active disease.

Since no evidence supports the development of resistance to penicillin by T. pallidum, a number of investigators have studied the ocular and CNS penetration of antibiotics. It has been shown that penicillin and benzathine penicillin do not penetrate these tissues in therapeutic levels. Erythromycin penetrates the eye adequately, but accumulates at levels lower than in the serum. A new therapeutic regimen with ampicillin trihydrate combined with probenecid has been suggested since this drug enters the ocular tissues in much higher concentrations. Goldman has reported improvement in clinical signs of ocular disease in congenital syphilitics with its prolonged administration. However, he also has reported recurrence of clinical disease and identification of spirochetes in aqueous humor during and after therapy.

The serologic tests for syphilis have not gone unnoticed. The most recent variation of the Wassermann, the VDRL, has proven to be the most widely used today. It remains a nonspecific reagin test for syphilis and as such is subject to infirmities such as false negatives and false positives. In 1962, fluorescein tagged anti-T. pallidum globulin was utilized for the first time in a serologic test for syphilis (FTA). This test is based on an antigen-antibody reaction. Initially it was very sensitive but nonspecific. By adding sorbants the group specific antibodies for treponemes in general were removed. The test is now specific and sensitive. The FTA-ABS test is considered 97+% accurate. No false positives have been reported. Published data has shown to be far superior in sensitivity to the VDRL. It is available at most hospitals and all state public health departments.

In summary, apparently spiral organisms exist in the human eye. All current information suggests that these organisms are identical or at least similar to T. pallidum, the causative agent of syphilis. They have been found before, during, and after the administration of large doses of antibiotics. They have been demonstrated in multiple body tissues from patients with late clinical syphilis. They have been found in a number of patients with negative serologic tests for syphilis (VDRL). The FTA-ABS test has proven itself more sensitive and specific than the widely used VDRL.

Summary of paper read before the National Society for the Prevention of Blindness, May 14, 1969, at Milwaukee.

Doctor Gager is Assistant Professor of Neuro-ophthalmology, Marquette School of Medicine, Milwaukee, Wis.

MEMBERSHIP DUES

Voluntary membership dues for 1969 of $100 are being accepted. Checks can be mailed to: Section on Ophthalmology, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. □

NEWS HIGHLIGHTS

Winnebago County Society Hears Dr. Darold Treffert

The Alcohol Treatment Program and Detoxification Center proposed for Mercy Hospital, Oshkosh, was discussed by Dr. Darold Treffert* at the March 6 meeting of the Winnebago County Medical Society.

The meeting was held at Winnebago State Hospital where Doctor Treffert is superintendent.

Discussants included Dr. Charles Cahill, Winnebago County Guidance Center; Mr. Kepfield, chief social worker and administrator of Winnebago County Guidance Center; Mr. Norman Whitford, director of the Winnebago County Department of Social Services, and Mr. Zabora, superintendent of Winnebago County Hospital.

In other business conducted at the meeting, the Society accepted the Executive Committee's recommendation that $100 be given in support of a survey on local health needs.

Dr. George W. Arndt* reported on the Area Health Planning meetings he attended in Madison and Fond du Lac.

It was announced that Dr. Robert Isom,* who is associated with Dr. Louis D. Graber* in Oshkosh, passed his Boards in surgery in February.

Medical Single Concept Films at Medical Library

Dr. S. E. Sivertson,* assistant clinical professor, medicine and medical administration, University of Wisconsin Medical Center, Madison, has announced that a series of 31 single concept cartridge films are available in the Middleton Memorial Library on the UW Campus. A projector housed in one of the glass conference cubicles shows the cartridge film.

The films are less than 20 minutes long and convey useful information and demonstrate techniques or tests which are comparatively simple when viewed but appear complex when described.

Topics available include: Cancer in Children; To Speak Again, Laryngectomy; Nursing Care of the Cancer Patient (Parts I and II); and Hemiplegic Patient (three films), and many others.

Doctor Sivertson welcomes anyone to use the films which are kept at the main desk, and invites comments regarding the continuance of the program.

MILWAUKEE GYNECOLOGICAL SOCIETY ELECTS OFFICERS

Dr. William J. Madden* of Racine has been elected president of the Milwaukee Gynecological Society for 1969–1970. Doctor Madden is the first member from outside the city of Milwaukee to head the organization which has a membership of 110 board certified and board eligible obstetricians and gynecologists in Wisconsin.

Dr. Richard Mattingly* of Milwaukee was elected president-elect. He is professor and chairman of the Department of Gynecology and Obstetrics at Marquette School of Medicine.

Dr. Samuel G. Perlson,* Milwaukee, was reelected secretary–treasurer.

TB Skin Tests, Crawford County

The Crawford County Medical Society in cooperation with the Public Health Nursing Services has agreed to give tuberculin skin tests for children in grades one and nine in Crawford County.

PHYSICIAN BRIEFS

Dr. Domingo Leonida

. . . formerly health director of Skokie, Ill., has assumed new duties as health director for the city of Kenosha.

Dr. Leo Hoffmann*

. . . of Campbellsport and other members of the Hoffmann family were featured in a recent issue of the APPLETON POST–CRESCENT. Doctor Leo was cited recently by the Fond du Lac County Medical Society, for at 75 years of age he still works a full day as the only doctor in the village of Campbellsport and the surrounding community. Other family members recalled in the article were Drs. Phillip A. Hoffmann, deceased, and J. Gregory Hoffmann,* who resides in Hartford.

Dr. Bahij S. Salibi*

. . . neurosurgeon at the Marshfield Clinic since 1958, was appointed councilor to the Central Neurosurgical Society at its meeting in Chicago March 22. The only other person ever named councilor to the Society is Dr. Oscar Sugar, professor of Neurosurgery at the University of Illinois College of Medicine in Chicago, under whom Doctor Salibi trained. Membership of the Central Neurosurgical Society is drawn from a number of midwest states including Wisconsin, Michigan, Illinois, Iowa, and Indiana. Doctor Salibi has served as president of the Society, and as moderator of the scientific program during the meeting March 22.

Dr. George C. Hank*

. . . Madison, has been named on a part-time basis to the new post of medical director at St. Mary's Hospital. The post is the first medical directorship created in the Madison area. Doctor Hank is the immediate past president of St. Mary's medical staff.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dr. Fred W. Fletcher*

. . . and Dr. Robert G. Norfleet,* Marshfield Clinic internists, have been inducted into the American College of Physicians. Doctor Fletcher has been elected a fellow and Doctor Norfleet has been named an associate member of the organization.

Dr. John M. Irvin*

. . . Monroe, recently was elected president of the Green County Medical Society. Other officers elected were: Drs. William E. Hein,* vice-president; Benjamin M. Rush,* secretary-treasurer; Robert G. Zach,* delegate; and Doctor Hein, corresponding alternate.

Dr. Kenneth G. Reeb*

. . . Madison, has been selected by the American Academy of Pediatrics to serve as a Headstart consultant in Wisconsin.

Dr. Kenneth K. Pavlik*

. . . Edgerton, recently was appointed health officer of that city, succeeding Dr. V. S. Falk* who resigned.

Dr. William C. Boake

. . . Dr. Joseph A. Glennon, and Bernard C. Korbitz,* all of Madison, have been named fellows in the American College of Physicians. Also named were Drs. Charles W. Young,* Platteville, Fred W. Fletcher,* Marshfield, and Robert E. Dedmon, Neenah.*

Dr. Hendrik Leering*

. . . Lake Mills, has been appointed Lake Mills health officer. He succeeds Dr. Earl Netzow* who resigned.

Dr. Richard E. Rieselbach

. . . Madison, assistant professor of medicine at the University of Wisconsin Medical School, recently was awarded the Markle Foundation Grant. Doctor Rieselbach was named Markle Scholar along with 24 other top medical scientists and faculty members around the United States and Canada. He is one of seven physicians who have represented Wisconsin in the 22 years of the program.

Two Medical Students to Serve Fellowships in Foreign Lands

Two junior medical students, one from the University of Wisconsin and the other from Marquette, have been awarded fellowships which will permit them to assist for 12 weeks this year at mission hospitals abroad.

Craig G. Stien of the UW and his wife, Phyllis, a registered nurse, have been awarded a $3,514 fellowship for a stay this summer in the Republic of Malagasy, Madagascar. Mr. Stien is from Stevens Point.

James T. Patten, a native of Queens Village, N.Y., has been awarded a $1,296 fellowship for a trip next winter to Rhodesia.

They are two of 31 American medical students selected to receive Smith Kline & French Foreign Fellowships from the Association of American Medical Colleges. The fellowships are supported by a grant from SK&F.

Mr. Stien's duties will include assisting in surgery and doing some surgery under supervision, helping with laboratory examinations, assisting in daily ward rounds, and reading x-rays. Mrs. Stien will assist at the mission hospital complex.

Mr. Patten will assist in medical treatment, in surgery, and in complicated deliveries. He also will travel to outpatient clinics which serve the rural area where the Driefontein Mission is located.

Now entering its tenth year, the Smith Kline & French Foreign Fellowships program was established to permit American medical students to widen their medical horizons in cultures different from their own.

Flu Virus in Wisconsin

The State Division of Health has indicated that a mild form of flu virus, influenza B, is apparently moving into Wisconsin from other states. Dr. H. Grant Skinner,* state epidemiologist, said that the State Laboratory of Hygiene has positively identified specimens from 15 patients as the B strain and that much of the flu now going around is probably this type.

Moderate to severe outbreaks of influenza B have been reported from other areas in the country, with some cities reporting school absenteeism as high as 45 percent.

Named to Marquette Board

Dr. Norman Becker* of Fond du Lac was one of six new members recently appointed to the board of directors of Marquette School of Medicine by Governor Knowles.

The school, which was severed from Marquette University last year in anticipation of receiving state aid, is governed by the board—one third of whose members are appointed by the governor.

Others appointed to the board are Joseph Heil, Sr., chairman of the Heil Co., Milwaukee; Ernest J. Philipp, Milwaukee; John Zancanaro, Fox Point; Kenneth L. Reed, Kenosha; and Mrs. Marie Uihlein, Grafton.

Deaconess Hospital Closing OB Unit

An announcement in April disclosed that Deaconess Hospital in Milwaukee will close its obstetrical unit by July 1, partly because of the continuing decline in Milwaukee's birth rate.

The hospital's executive director, Kenneth S. Jamron, in making the announcement stated that in the late 1950s Deaconess had up to 3,000 deliveries a year but the hospital had slightly more than 500 deliveries in 1968. According to a private consultant's study and guidelines issued last year by the hospital area planning committee (HAPC), the hospital should perform a minimum of 1,500 and preferably 2,000 deliveries a year in order to maintain high medical personnel proficiency.

Mr. Jamron added that most physicians who have been delivering babies at Deaconess will be accepted on the staff of a neighboring hospital.

Dr. E. A. Bachhuber to Head TB Group

Dr. Edward A. Bachhuber,* Wauwatosa, was elected president of the Wisconsin Tuberculosis and Respiratory Disease Association at its annual meeting of the board of directors March 28 in Milwaukee.

Dean Gordon E. Brant, Eau Claire, was elected president-elect. Dr. Benjamin G. Narodick,* Whitefish Bay, was elected vice-president.

Reelected were Dr. Elwood W. Mason,* Whitefish Bay, secretary; and Asher B. Nichols, Jr., Whitefish Bay, treasurer.

Eight members of the board of directors of the WTRDA were reelected. They are Dr. Henry A. Anderson,* Stevens Point; Edward R. Bowser, Superior; Charles W. Chapman, West Bend; T. A. Duckworth, Wausau; Mrs. James A. Fields, Milwaukee; Donald C. Gates, Fox Point; Dr. E. H. Jorris,* Madison; and Mrs. Konrad Testwuide, Sheboygan.

Dr. Jack C. Westman*

. . . speaking at the 66th annual meeting of the Lad Lake, Dousman, school for emotionally disturbed boys, stated that he foresees regional instead of self-contained treatment centers for emotionally disturbed children. Doctor Westman, who is professor of psychiatry at the University of Wisconsin Medical School, Madison, predicted a situation where the staff of places such as Lad Lake would reach more and more out into the surrounding area with halfway houses and parent therapy and community involvement. It will involve more of a program and not just a physical plant, he said.

Dr. Paul S. Rosenfeld

. . . has been appointed assistant professor of medicine at Marquette School of Medicine, Milwaukee, and will be chief of the Endocrinology and Metabolic Section at Veterans Administration Hospital, Wood. Before joining the Marquette staff, Doctor Rosenfeld served as a research internist in the Department of Metabolism at Walter Reed Institute of Research, Washington, D.C.

Dr. J. M. B. Bloodworth*

. . . Madison, professor of pathology at the University of Wisconsin Medical School, recently attended the Sixth Annual Meeting of the Aspen Diabetes Institute, Aspen, Colo.

Dr. Thomas F. Jennings*

. . . Elm Grove, recently was elected chief of the Department of Obstetrics and Gynecology at Trinity Memorial Hospital. He has been a member of the Trinity medical staff since 1960 and was elected to a two-year term of office.

Dr. Herbert W. Pohle*

. . . of Milwaukee was elected to a three-year term on the Board of Governors of the American College of Physicians at its 50th annual session April 24 in Chicago.

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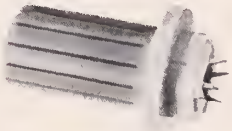

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF APRIL 1969

2 Madison Anesthesiology Society

2 Committee on History of Nursing, Wisconsin Nurses Association

3 SMS Division on School Health

7 State Board of Pharmacy Examination

7 Dane County Medical Society Insurance Advisory Committee

9 SMS Grievance Committee

9 Madison Area Radiologists

10 SMS Commission on Hospital Relations and Medical Education

10 Madison Academy of Internal Medicine

12 SMS Executive Committee of Council

13 Executive Board, Wisconsin State Medical Assistants Society

14 Dane County Medical Society Utilization Review Plan

16 Planning Committee, Wisconsin Regional Medical Program

16 SMS Commission on Health Information and Wisconsin Rural Health Leaders

17 Senior Student Health Club, Solomon Juneau High School

17 Executive Committee, SMS Commission on Medical Care Plans

17 Woman's Auxiliary to Student American Medical Association

18 Reciprocity Interviews by State Medical Examining Board

19 Medical Careers Day for High School Students

23 Photography Contest Judging for 1969 SMS Annual Meeting

23 Trained Practical Nurse Examinations of Wisconsin Board of Nursing

30 Advisory Committee on Health Careers, Wisconsin Health Council

30 Board of Directors, Wisconsin Health Council

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

State Medical Assistants Society to Hold Annual Convention

The Wisconsin State Society of the American Association of Medical Assistants will hold its 14th annual convention at the Ramada Sands in Milwaukee June 6–8.

The House of Delegates will convene on Friday, June 6, and the education session on Saturday, June 7.

Joe Dorsey, Milwaukee radio personality, will serve as master of ceremonies at the installation banquet Saturday evening.

The Wisconsin state president, Mrs. Jane Staszewski of Big Bend, will complete her term of office at this time. Miss Phyllis Schirmer of Milwaukee will be installed as the new president.

At 9:30 Saturday morning, Dr. William Kisken,* assistant professor of surgery at the University of Wisconsin, Madison, will talk about "Ethical Problems in Medical Advance."

The Rev. Hugh McGinley, OP, chaplain and staff counselor at Lutheran Hospital, Park Ridge, Ill., will discuss "Alcoholism—The Neglected Disease" at 10:30 Saturday morning.

In the afternoon at 2 o'clock a panel discussion entitled, "What Would You Do If?," will be moderated by Miss Alice Budny of Milwaukee, past president of AAMA. Participants will be Miss Edith Murphy, past state president; Miss Catherine Fuhrman, CMA; and Mrs. Karen Horwath, all of Milwaukee.

Following a brunch on Sunday morning, June 8, the new president, Miss Schirmer, will preside at a session summarizing the proceedings of the House of Delegates.

The American Association of Medical Assistants is an educational, nonprofit organization designed to maintain and advance standards of professional self-improvement among its 12,500 members, including medical secretaries, nurses, technicians, and other personnel employed or supervised by licensed physicians.

To Aid Home Nursing Service

A Medical Advisory Committee consisting of four physicians from the Tri-County (Ashland–Bayfield–Iron) Medical Society has been established to review medical policies and programs of the Bayfield County Home Nursing Service. Members are Drs. Joseph Jauquet,* John Telford,* Kenneth Morrow,* and A. A. Koeller.*

Workshop on Scoliosis

In August there will be a Workshop for the Treatment of Scoliosis and Round Back with the Milwaukee Brace by Marquette School of Medicine and Milwaukee Children's Hospital, Milwaukee.

DR. ABRAHAM SCHWARTZ DIRECTOR BIRTH DEFECTS CENTER IN MILWAUKEE

Dr. Abraham B. Schwartz,* former chairman of Marquette School of Medicine's pediatrics department, has been appointed director of the Birth Defects Center at Milwaukee Children's Hospital.

Doctor Schwartz heads this service which coordinates the hospital's facilities for patients with birth defects. In January 1968, the National Foundation awarded a two-year grant of $69,000 for the center's establishment.

Physicians who see pediatric cases but who on their own cannot provide comprehensive care, refer children to the center. The center's staff registers patients, evaluates their needs, and guides the patient's family in choosing the right medical, social, and educational care. Recommendations are made to the referring physicians, and records are kept of the follow-through procedures.

Doctor Schwartz served as chairman of the medical school's pediatrics department from 1952–1953. He received the rank of clinical professor of pediatrics, emeritus, in 1962.

CONTRIBUTIONS—CES FOUNDATION

March 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for March 1969.

Nonrestricted

State Medical Society	Voluntary contributions of 250 MDs
Mr. and Mrs. Richard J. Toser	Memorial: Richard D. Bartholomew, Jr.
Richard and Lorraine Schedler	Memorial: Richard D. Bartholomew, Jr.
Dane County Medical Society	Memorial: Dallas V. Clatanoff, MD
Mr. and Mrs. John C. LaBissoniere	Memorial: Peter M. Dorr
Robert B. Murphy	Memorial: Vincent W. Koch, MD
E. J. Nordby, MD	Memorial: Vincent W. Koch, MD
Dr. and Mrs. Albert Freedman	Memorial: Edgar Branson
Wisconsin Physicians Service	Memorial: Ralph H. Vogel
State Medical Society	Memorial: Ralph E. Morter, MD
State Medical Society	Memorial: Dallas V. Clatanoff, MD
State Medical Society	Memorial: Noel Peter Braun, MD
State Medical Society	Memorial: William Lumsden, MD
State Medical Society	Memorial: Vincent W. Koch, MD
State Medical Society	Memorial: Joseph J. Gramling, MD
State Medical Society	Memorial: William O. Thomas, MD
State Medical Society	Memorial: Thomas Lubitz

Museum of Medical Progress

State Medical Society	Voluntary contributions of 4 MDs

Student Loans

State Medical Society	Voluntary contributions of 54 MDs

Charitable

State Medical Society	Voluntary contributions of 28 MDs

Scientific Teaching

State Medical Society	Voluntary contributions of 6 MDs

Tormey Memorial Fund

State Medical Society	Voluntary contribution

Donations Other Than CESF Projects

State Medical Society	Voluntary contributions of 26 MDs

Wisconsin Academy of General Practice Loan Fund

State Medical Society	Voluntary contribution

General Memorials

State Medical Society	Voluntary contribution

Danforth Medical Student Loan Fund

Mrs. Quincy H. Danforth	Voluntary contribution

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorial: Norwood T. Bryant
Robert B. Murphy	Voluntary contribution
C. H. Crownhart	Memorial: George H. Scanlon, MD

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Voluntary contribution

PUBLIC AFFAIRS PAMPHLET NO. 429

When Should Abortion Be Legal?

By Harriet F. Pilpel and Kenneth P. Norwick

Available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N. Y. 10016.

PUBLIC AFFAIRS PAMPHLET NO. 432

We Can Conquer Uterine Cancer

By Elizabeth Ogg

Available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N. Y. 10016.

Dr. James H. Brandenburg*

. . . Madison, chairman of the Department of Otolaryngology, University of Wisconsin Medical School, recently was inducted into the American Laryngological, Rhinological and Otological Society at the 72nd Annual Meeting held in New Orleans Mar. 23–26.

Dr. A. M. Jerofke*

. . . Cudahy, accepted the position of city school physician. The position has been vacant since the resignation of Dr. Richard Anderson in December.

Dr. Adolph Stafl

. . . and his wife, Dr. Jaraslava Staflova have joined the Marquette School of Medicine faculty. Doctor Stafl is assistant professor in the Department of Gynecology and Obstetrics while his wife is on the ophthalmology staff as a research associate. They escaped from Czechoslovakia during last summer's uprising and joined the Johns Hopkins medical school staff.

Dr. Naldo Thung*

. . . and Dr. Nancy Wu,* Madison, Department of Anesthesiology, University of Wisconsin Medical School, presented their scientific exhibit on the "Effects of Anesthesia and Surgical Operations Upon Respiratory Functions," at the Annual Clinical Congress of Abdominal Surgery in Las Vegas, Nev., Mar. 23–26.

Dr. Andrew L. Banyai*

. . . Chicago, Ill., clinical professor of medicine, emeritus, Marquette School of Medicine, and past president of the American College of Chest Physicians, was elected honorary member of the "Koranyi Frigyes" Hungarian Medical Association for Tuberculosis and Pulmonary Diseases, at Budapest, Hungary, in March.

Dr. Alfred J. Coron*

. . . of Milwaukee, recently opened an office in Watertown. Doctor Coron served in the U.S. Army during the Korean conflict. He graduated from the University of Wisconsin Medical School and interned at Columbia Hospital and Milwaukee Children's Hospital.

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

MEDICARE VISITORS

They Come with Questions . . . They Leave with Answers

Nearly 100 persons each week come to the State Medical Society building in Madison seeking advice and information about their health care insurance. Another 1500 persons telephone weekly with similar inquiries. Most of these people are over age 65 and have purchased benefits under Part "B" of Medicare.

Wisconsin Physicians Service, the insurance division of the State Medical Society, provides advice and counsel to these people through its Subscriber Services staff who is trained to greet these callers and provide them with the help and counsel they seek. Many are members of the public who learn of this WPS service through friends and neighbors.

Subscriber Services people have found that questions of these Medicare callers often fall into one of three rather broad categories:

ONE. Most often the visitor has not used his Medicare coverage previously and is unsure of what benefits he is entitled to and how to go about claiming them.

A Subscriber Services interviewer shows him the proper method of completing a claim form, how to submit it, and what to expect from Medicare when his claim has been processed.

TWO. A second type of caller is one who has just received his first "Explanation of Benefits" form from Medicare and is not sure just what it means. Often he thinks it is a bill from WPS, or he wants to pay WPS the $50.00 "deductible amount he owes." Much patience and many simple words by Subscriber Services staff are needed before the beneficiary understands Medicare payment procedures and how they affect his particular claim for benefits.

THREE. More frequently a third type of visitor is seen. This is the person who is eligible for Medicare but who also has or would like to have "a policy to pay for things that Medicare does not pay."

Again the interviewer calls on his supply of simple words, his tried and true explanation techniques, and his handy "How WPS Pays Expenses Medicare Does Not" chart to "show and tell" just how Medicare-PLUS $15,000 (available only from WPS) supplements and extends federal Medicare benefits. If the visitor already has Medicare-PLUS $15,000, he is given a simple explanation of how to apply for benefits. If the visitor has supplementary benefits from another insurance carrier, he is referred to that carrier for advice on how to claim benefits under its contract.

A member of Subscriber Services explains Medicare benefits.

In addition to the three "standard" types of office visitors, there are those who are hard of hearing and those who have a problem, question, or gripe "that is uniquely their own." For this group the interviewer must come up with a double handful of simple words and patience and then settle for a longer than "the usual 30-minute" interview.

The WPS Subscriber Services staff accomplishes a personal service to Wisconsin people who otherwise must seek out the answers to their questions through a federal Medicare office.

Placement Service

The State Medical Society's Placement Service has registered with it a number of specialists and general practitioners. Contact the PS by writing to Box 1109, Madison, Wis. 53701. □

Dr. C. G. Reznichek*

. . . Madison, recently was featured in "Know Your Madisonian" in the WISCONSIN STATE JOURNAL. Doctor Reznichek's contributions to the city and state have been many in the past 34 years. In 1950–51, as president of the Dane County Medical Society, he helped organize the first code of medical-press relations for Wisconsin, providing guidelines as to what medical information could legally and ethically be made public. A member of the State Medical Society of Wisconsin, he served for 20 years on the Commission on Medical Care Plans and in 1950 he helped organize the Madison chapter of the Wisconsin Academy of General Practice. Doctor Reznichek also served as representative of the American Academy of General Practice to an American Medical Association task force studying the planning, training, and operational organization needed for national emergency medical care.

Dr. T. Alun Phillips

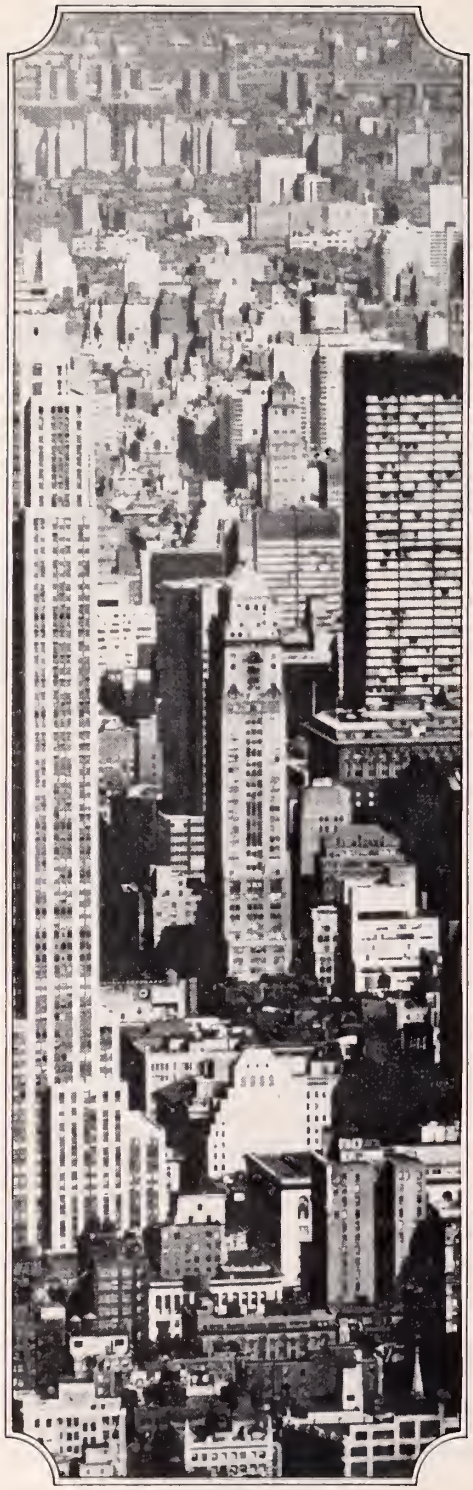
. . . who has been practicing for the last five years at Owen, will be leaving May 31 to return to his home in Wales, Scotland, where he will open a practice.

Dr. Frank Cerny*

. . . and his wife, Fond du Lac, in June will be returning to a missionary clinic in Nigeria for the third time. They have volunteered their time and services to work in the clinic. Doctor Cerny is an eye, ear, nose, and throat specialist and his wife is a nurse. Their two teenage sons will accompany them for the four-week stay.

Dr. J. L. Weygandt*

. . . of Sheboygan Falls is a member of the newly organized Sheboygan County Highway Safety Commission. The 15-member commission met for a "get acquainted" affair Jan. 29 in Sheboygan. The commission was formed to comply with the National Safety Act of 1966, to act as an advisory board to the Sheboygan County Board and the State Highway Department. □



118th Annual Convention AMA NEW YORK CITY JULY 13-17, 1969

The magnetism and the grandeur that characterizes New York City will provide a superb setting for AMA's 118th Annual Convention in July. Plan to attend now and look forward to five memorable and stimulating convention days in a city of unlimited excitement.

Continue your postgraduate education with a varied program of • four General Scientific Meetings on Chronic Pulmonary Insufficiency and Problems of Air Pollution, Human Sexuality, Impact of Medical Education on Patient Care, and Physical Fitness and Aging • 23 Section Programs • Color Television • Medical Motion Pictures • and over 700 scientific and industrial exhibits. The nation's outstanding medical authorities will lecture and discuss the significant advances in today's medicine.

In addition the AMA TV network will present more than 40 hours of convention programming.

Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, July 16, 1969. Since space is limited, we suggest you make your reservations before June 30, 1969. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 26, 1969.

NEW YORK CITY, NEW YORK • JULY 13-17, 1969
AMERICAN MEDICAL ASSOCIATION'S 118th ANNUAL CONVENTION

OBITUARIES

Dr. Benjamin H. Schlomovitz, 79, Milwaukee, died Jan. 12, 1969, in Milwaukee.

Born on May 18, 1889, in Milwaukee, he graduated from Rush Medical College in 1917 and did teaching and research work at Rush, Iowa State Medical College, University of Wisconsin and Marquette medical schools.

Doctor Schlomovitz served as a civilian in Chemical Warfare Service in World War I, and after the war he started his practice in Internal Medicine with special interest in Pathology. He was formerly a consultant and director of the laboratory at the Wood Veterans Administration Hospital for 20 years.

Doctor Schlomovitz was a member of the American Physiological Society, American Heart Association, and Wisconsin Trudeau Society. At the State Medical Society's annual meeting in May 1967, he became a member of the "50-Year Club."

Doctor Schlomovitz was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Phyllis, and two children.

Dr. William L. Herner, 84, former medical director at Sacred Heart Sanitarium, Milwaukee, died Feb. 4, 1969, in La Jolla, Calif.

Born Dec. 16, 1885, in Syracuse, New York, Doctor Herner graduated from Marquette University School of Medicine in 1908 and interned at Mercy Hospital, Oshkosh. He joined the staff of the Sacred Heart Sanitarium in Milwaukee in 1913, served as its medical director for 31 years, and retired in 1963 after 50 years of service.

Doctor Herner was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his sister, Mrs. Paul Strange, La Jolla, Calif., and a brother, Morrow, Appleton.

Dr. Joseph J. Gramling, Sr., Milwaukee's oldest practicing physician, died Mar. 9, 1969, in Milwaukee at the age of 87.

Doctor Gramling had practiced in the Milwaukee area for 64 years and had made house calls the day before his death.

Born June 26, 1881, on a farm near Dousman, Wis., Doctor Gramling completed his premedical studies at Valparaiso, Ind., and was graduated from the old Milwaukee Medical College, now the Marquette School of Medicine, in Milwaukee in 1905.

He was a member of St. Luke's Hospital medical staff from its beginning in 1928 until his death. At one time he headed the department of medicine. He was on the faculty of the old Marquette University School of Medicine and on the staff of the old Trinity Hospital.

For many decades he was a director and for several years medical director of the Catholic Family Life Insurance Company.

Doctor Gramling was nationally known as a breeder of Holstein–Friesian cattle which he raised on the family homestead at Dousman.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. In 1960, he was granted a life membership in the State Medical Society.

Doctor Gramling's wife died in 1913. He is survived by two sons, Dr. Joseph J. Gramling, Jr., Wauwatosa; and James A. Gramling, Elm Grove; and two daughters, Mrs. Joseph A. (Dorothy) Becker, Wauwatosa; and Mrs. Herbert N. (Margaret) Pasteur, Elm Grove.

Dr. Joseph E. Halloin, 71, Green Bay physician for 35 years, died Mar. 17, 1969, at Plantation, Fla.

Born Oct. 5, 1898, in Green Bay, Doctor Halloin graduated from the Marquette University School of Medicine in 1928, interned and practiced for three years at Appleton. He returned to Green Bay in 1930 and retired in 1965.

He was formerly a member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Dorothy; and a son, John, Madison.

Dr. William H. Dohearty, 90, former Wauwatosa resident, died Mar. 26, 1969, in Glendale.

Born July 22, 1878, Doctor Dohearty graduated from the Marquette University School of Medicine in 1907 and interned at Trinity Hospital, Milwaukee. He practiced in West Allis until his retirement in 1967 and was a staff member of St. Mary's Hospital for more than 34 years.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are two sons, Joseph A., Milwaukee, and Michael W., Dallas; and a daughter, Mrs. William (Patricia) J. Keating, Whitefish Bay.

Dr. David A. Maas, 79, former Webster physician, died Apr. 1, 1969, in Madison.

Born on Apr. 28, 1889, Doctor Maas graduated from the College of Medicine and Surgery, Chicago, Ill. in 1916. He practiced in Danbury and Balsam Lake, Wisconsin, before moving to Webster in 1928. He retired from practice in 1963 and moved to Montana.

He was a member of the Polk County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Freda; one son, David, Middleton and a daughter, Mrs. Gerald (Marie) Delin, Bozeman, Mont. □

WISCONSIN HEALTH

By E. H. JORRIS, MD, State Health Officer

NEW TEST FOR WHOOPING COUGH TO AID CONTROL

The common case of whooping cough can be easily recognized by physicians after the typical symptoms appear. But an infected person may be spreading the disease around for several days before the disease can be diagnosed. Thus to hold down the spread of the infection, a means of early diagnosis is important to physicians and public health workers. The fluorescent light test, a new quick technique for detecting pertussis, was recently introduced in Wisconsin by the State Laboratory of Hygiene. Physicians can now take swab samples for smears from the nasal passages and test them, by the fluorescent light method for preliminary diagnosis. A final diagnosis can be obtained from samples sent to the Laboratory of Hygiene for culturing. While waiting for the results of the final test, suspected positive cases will be isolated to avoid spread of the disease.

When antibiotics were introduced several years ago and led to the early cure of whooping cough, its incidence in our population dropped sharply. With the widespread use of this positive diagnostic test we can, hopefully, anticipate an even greater decline in the appearance of this distressing disease. □

MEDICAL MEMORABILIA

COINS AND MEDALLIONS

MEDICINE IN ART

OLD TIME DRUG STORE

EXHIBITS OF MEDICAL HISTORY

PRESERVATION OF MEDICAL RECORDS

HOBBIES FOR HEALTH

HISTORICAL ARTIFACTS

SPECIALIZED STAMPS

the Section on Medical History

CREATED IN 1953

"Dedicated to the Preservation of Our Medical Heritage"

It has been said, and truthfully:
"History is not only that which is hundreds of years old. History is today's events. They should be recorded for the time when they can be evaluated in the light of experience and impartiality."

THANKS to Dr. William S. Middleton—who has done so much for medicine, his state, and his country—for adding five stethosopes to our collection.

One of them dates back to the early 1800s and was used by Stephen T. Hume, both as a student and as a practitioner. He received his degree in 1818. His daughter, Ella Hume Taylor, presented it to William A. Mowry, MD of the University of Wisconsin who gave it to Doctor Middleton.

In 1967, the State Medical Society built a diorama on the "invention" of the stethoscope. It is based on the painting by Robert A. Thom, one of a series—"Great Moments in Medicine"—commissioned by Parke–Davis. It is narrated by Dr. H. Kent Tenney, and it has proven a popular exhibit. Funds for the original exhibit were donated by the Wisconsin Society of Internal Medicine.

CONTRIBUTIONS OF ARTIFACTS AND MEMORABILIA ARE ENCOURAGED. IF YOU CAN PERSONALLY CONTRIBUTE, OR YOU KNOW OF SOMEONE WHO WOULD LIKE TO, PLEASE INFORM THE SOCIETY OFFICE. ARRANGEMENTS CAN BE MADE FOR PICKUP OF ITEMS IF NECESSARY.

HISTORICAL MARKERS

MANUSCRIPTS AND PAPERS

MEDICAL MUSEUM

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MARCH 19, 1969

NEW MEMBERS

Chun, Raymond W. M., 1300 University Ave., Madison 53706
Ebling, Paul R., 2500 Overlook Terr., Madison 53705
Greischar, Robert, 804 East Irving Ave., Oshkosh 54901
Lulloff, Kim H., 111 East North Water St., Neenah 54956
Marden, Philip M., 1300 University Ave., Madison 53706
Moore, Clarence E., 409 Berkley Place, Fond du Lac 54935
Nahn, Charles E., 1313 Fish Hatchery Rd., Madison 53715
Plos, James R., 2121 Bowen St., Oshkosh 54901
Skibba, Joseph L., 5610 Barton Rd., Madison 53711

REINSTATED

Johnson, Frances, 425 East Wisconsin Ave., Milwaukee 53202

CHANGES OF ADDRESS

Angevine, D. Murray, Madison, to Dept. of the Army, Armed Forces Institute of Pathology, Washington, D. C. 20305
Banda, Pedro N., 1418 West Edgerton Ave., Milwaukee 53221
Beatty, S. R., 1209 South Commercial St., Neenah 54956
Bolton, Robert L., 10425 West North Ave., Wauwatosa 53226
Borsack, Karl K., 525 East Division St., Fond du Lac 54935
Conklin, John W., Waukesha, to 724 Orleans St., Bogulusa, La. 70427
Dettmann, Frederick G., Neenah, to 422 Broad St., Menasha 54952
Dundon, John R., 135 West Wells St., Suite 505, Brumder Bldg., Milwaukee 53203
Edson, Jack, Eau Claire, to Wales 53183
Enzer, Norbert, Box 342, Milwaukee 53201
Frank, Eugene B., 34810 West Pabst Rd., Oconomowoc 53066
Frechette, Paul F., 19 Glenway St., Madison 53705
Gandy, Theodore, 4167 North Downer Ave., Milwaukee 53211
Hargarten, L. W., Milwaukee, to 77–090 Florida Ave., Palm Desert, Calif. 92260
Hoelscher, Freidrich E., 5225 North 29th St., Milwaukee 53209
Huebner, Jewel S., 525 East Division St., Fond du Lac 54935
Jaques, Darrel A., Washington, D. C., to Beaumont General Hospital, Box 660, El Paso, Tex. 79920
Johnson, Paul S., 3654 North Bay Dr., Racine 53402
Kulkaski, Bernard, 530 South Irwin Ave., Green Bay 54301
Langheim, Werner E., 20 South Park St., Madison 53715
Leenhouts, Kenneth C., Waukesha, to P. O. Box 96, Menomonee Falls 53051
McLaughlin, John T., Manchester, New Hampshire, to 2718 San Carlos Ave., Costa Mesa, Calif. 92625
Meisekothen, William, 5113 Monona Dr., Madison 53716
Moel, Morris, P. O. Box 342, Milwaukee 53201
Olson, Donald R., 5921 Hempstead, Madison 53711
Pope, F. W., P. O. Box 1176, Racine 53405
Rubin, David, Box 342, Milwaukee 53201
Rustia, Ricardo M., Winneconne, to Box No. C, Pulaski 54162
Ryan, Donald Joseph, 1209 South Commercial St., Neenah 54956
Schibly, William J., 530 South Irwin Ave., Green Bay 54301
Schneider, J. Morton, Madison, to 880 Dexter St., Apt. 107, Denver, Colo. 80220
Seidl, Joseph, Grafton, to American Motors, 3880 North Richard St., Milwaukee 53201
Sheldon, Edwin, Jr., 2727 Marshall Ct., Madison 53705
Sievert, Robert A., 202 South Park St., Madison 53715
Simonsen, Thomas E., A. P. O. San Francisco, Calif., 96343, to 3635 Daisy Lane, Racine 53405
Sladky, James A., St. Mary's Hospital, 4320 North Lake Dr., Milwaukee
Smith, Ernest V., Jr., 525 East Division St., Fond du Lac 54935
Stone, Richard, 2811 Arrowhead, Rapid City, South Dakota 57701
Swissman, Neil, Mequon, to 836 North 28th St., Milwaukee 53208
Tibbetts, Palmer G., 3168 South 27th St., Milwaukee 53215
Thomas, Herman Ray, 525 East Division St., Fond du Lac 54935
Vinluan, Alejandro M., 611 North Broadway, Suite 208, Milwaukee 53202
Voet, Raymond K., Bethesda, Md., to 1813 Chatham St., Racine 54402
Wrigley, John B., 3025 Somerton Rd., Cleveland Heights, Ohio 44118

REMOVED FROM MEMBERSHIP

Harkness, John W., Milwaukee County, resigned
Martinex–Larre, Marcial, Racine County, transferred to New York
Snider, Gordon L., Milwaukee County, resigned
Stageman, John F., Barron, Washburn, Sawyer, and Burnett County, transferred to Michigan

DEATHS

Morter, Ralph E., Milwaukee County, Nov. 29, 1968
Thomas, William O., Rock County, Jan. 23, 1969
Klein, Richard J., nonmember, Feb. 6, 1969
Clatanoff, Dallas V., Dane County, Feb. 9, 1969
Braun, Noel Peter, Sheboygan County, Feb. 13, 1969
Lumsden, William, Eau Claire–Dunn–Pepin County, Feb. 15, 1969
Dobbins, Thomas, nonmember, Mar. 1, 1969
Koch, Vincent W., Rock County, Mar. 5, 1969
Gramling, Joseph J., Milwaukee County, Mar. 9, 1969 □

DRUG COSTS, PRACTICAL TIPS ON USING PRESCRIPTION DRUGS DISCUSSED IN NEW CONSUMER BOOKLET BY PMA

"The Medicines Your Doctor Prescribes" is the title of a new 8 page letter-sized booklet published by the Pharmaceutical Manufacturers Association.

Intended for wide distribution among consumers of prescription drug products, the booklet discusses the relationship of the doctor, the pharmacist, and the patient in prescription drug use. It points out that such drugs actually are "medical treatment in product form."

The publication offers a number of practical tips to insure the safe and effective use of prescription drugs, and suggests that consumers not only budget the cost of health as a literal "living" expense but also consider pre-payment insurance for prescription drugs.

Copies are available upon request to PMA, a nonprofit scientific and professional trade association representing the manufacturers of 95 per cent of the nation's prescription drug products. □

★

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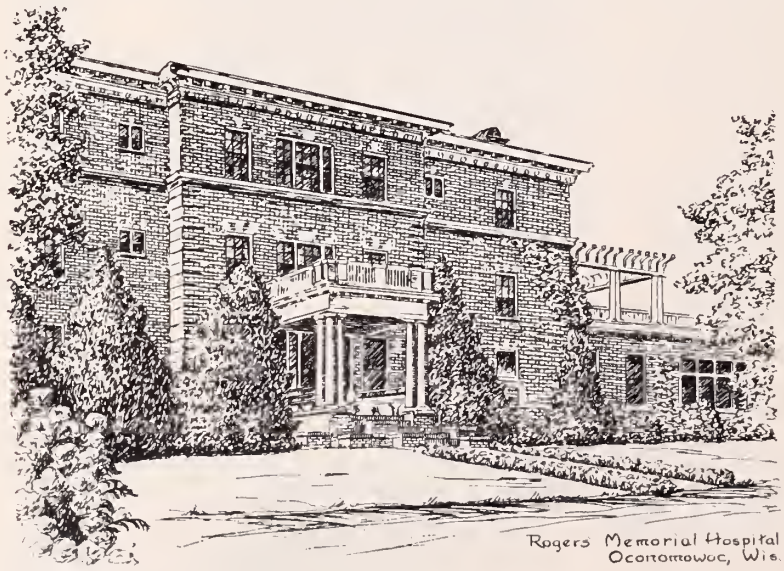

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

LOREN J. DRISCOLL, M. D.

THOMAS J. GORAL, M. D.

JOHN J. O'HARA, M. D.

EARL F. WEIR, M. D.

LEROY WAUCK, Ph. D.
Clinical Psychologist

ROBERT TESTIN, Ph. D.
Clinical Psychologist

Phone 567–5535

MILWAUKEE OFFICE—273–6622

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A NEUROPSYCHIATRIC FOUNDATION—OCONOMOWOC, WISCONSIN

A neuropsychiatric foundation for the intensive medical treatment of neurological and psychiatric disorders. Complete facilities for Occupational and Recreational Therapy under the direction of trained personnel.

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706

BOOKS RECEIVED

MODERN TREATMENT
Vol. 5, No. 5. Treatment of Common Allergic Problems, guest editor, Roy Patterson, MD and Rehabilitation, guest editor, Daniel J. Feldman, MD, Hoeber Medical Division, Harper & Row, Publishers, 49 East 33 St., New York, N. Y. 10016. Published bimonthly. 1.500 pages annually. Subscription: $16 per yr.

WATER AND ELECTROLYTE METABOLISM AND ACID-BASE BALANCE
By Edward Muntwyler, Professor and Chairman, Department of Biochemistry, State University of New York, Downstate Medical Center, Brooklyn, N. Y. Published by C. V. Mosby Co., Saint Louis, Mo. 1968. 169 pages. Price: $5.85

PHYSIOLOGY OF THE GASTROINTESTINAL TRACT
By E. Clinton Texter, Jr., MD, Ching–Chung Chou, MD, Higino C. Laureta, MD, and Gaston R. Vantrappen, MD. Published by the C. V. Mosby Company, Saint Louis, Mo. 1968. 262 pages. Price: $10.75

SURGERY OF THE ADRENAL GLANDS
By Lawrence W. O'Neal, MD, Assistant Professor of Clinical Surgery, Washington University School of Medicine. Published by C. V. Mosby Company, Saint Louis, Mo., 1968. 295 pages. Price: $19.50

COMMUNICABLE AND INFECTIOUS DISEASES
By Franklin H. Top, Sr., MD. Sixth Edition. C. V. Mosby Co., Saint Louis, Mo. 1968. 755 pages. Price: $28.50

HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES
By Charles Varga, MD, Associate Clinical Professor of Pediatrics, University of Oregon Medical School. Published by C. V. Mosby Co., Saint Louis, Mo. 1968. 694 pages. Price: $19.75

BRAY'S CLINICAL LABORATORY METHODS
By John D. Bauer, Philip G. Ackermann, and Gelson Toro. 7th Edition. C. V. Mosby Co., Saint Louis, Mo. 1968. 764 pages. Price: $14.85

ATLAS OF EAR SURGERY
By William H. Saunders, MD, and Michael M. Paparella, MD. C. V. Mosby Co., Saint Louis, Mo. 1968. 363 pages. Price: $27.50

PRACTICAL PSYCHIATRY FOR THE INTERNIST
By Douglas Goldman, MD, and George A. Ulett, MD. C. V. Mosby Company, St. Louis, Mo. 1968. 168 pages. Price: $9.85

COMPREHENSIVE REVIEW FOR THE RADIOLOGIC TECHNOLOGIST
By Matthew Stevens, and Robert I. Phillips. C. V. Mosby Company, St. Louis, Mo. 1968. 181 pages. Price: $7.25

QUESTIONS AND ANSWERS ON CONTACT LENS PRACTICE
By Jack Hartstein, BS (med), OD, MD. The C. V. Mosby Company, St. Louis, Mo. 1968. 199 pages. Price: $10.75

SURGICAL PATHOLOGY
By Lauren V. Ackerman, MD, and Harvey R. Butcher, Jr., MD. 4th Edition. The C. V. Mosby Company, St. Louis, Mo. 1968. 1140 pages. Price: $27.50

BOOK REVIEWS

THE PRE-SCHOOL CHILD'S LEARNING PROCESS

Edward B. Rosenberg, B.S. and Silas L. Warner, M.D., Instructor in psychiatry, University of Pennsylvania Medical School; Consultant in Psychiatry, Swarthmore College; Associate Staff, Institute of Pennsylvania Hospital, Budlong Press Co., Chicago, Ill., 1967. 102 pages. Price: $1.50.

This booklet of 102 pages on *The Pre-School Child's Learning Process* is designed to inform new parents on the subject of how young children learn and develop. The language is clear and easily readable. The discussion presents with clarity the fact that learning occurs in a progressive continuum and within a relatively wide range. When specific ages are mentioned they are realistic.

The one short reaction on how parents affect the desire to learn on page 49, was in my estimation much too short and brief for such a significant part of the child's learning process, although this topic is partially covered in other sections under other titles.

The section on discipline will prove very useful to most parents, a topic which I have found causes the most conflict and confusion in young parents today.

The booklet on the whole is well organized and covers the topics in an orderly fashion from the early phases of learning to the use of nursery schools and preparation for the first day of regular school are covered adequately. The points made should be useful for most parents to orient them to an appropriate attitude to their child. The main message that pervades the booklet is a comfortable relaxed attitude that successfully conveys the idea that a child's development is a natural process that flourishes in a calm, encouraging atmosphere and suffers if too much pushing and pulling on the child prevails. The illustrations implement this well.

This booklet can be recommended for all parents interested in reading to further their knowledge about their young child.—HAROLD F. BORENZ, M.D.

THE EFFECTS OF EXTERNAL STIMULI ON REPRODUCTION

Ciba Foundation Study Group No. 26, Little Brown & Company, 1967. 107 pages.

In honoring Professor Zondek, this group of twenty outstanding investigators has presented and discussed a wealth of exciting data and ideas concerning animal and human reproduction, many of which are clearly pertinent to our present day society. Such researches are rapidly providing a greater degree of understanding of the physiological and psychological mechanisms involved in the numerous demonstrated effects on experimental animals of sound, light, odors, and other external stimuli. More and more important clinical applications of this knowledge are certain to ensue.—H. W. MOSSMAN, Ph.D.

continued on page 70

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For further information, please contact N. A. Moffat, MD, Procurement Chairman, Marshfield Clinic, Marshfield, Wis. 1tfn

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WANTED: Personable family physician to join group of five family physicians and one surgeon. Contact West Madison Clinic, James Moore, MD, 5510 Medical Circle, Madison, Wis. 53711. Tel. (area code 608) 238–3111. 5–9

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□

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NUTRITION AND INFECTION

Ciba Foundation Group #31. Little, Brown & Co., Boston, 1968. 151 pages. Price: $3.50.

This short book contains a series of papers presented at a one-day conference honoring Ragnar Nicolaysen of the Institute for Nutrition Research, University of Oslo.

Short chapters dealing with the subjects of placental malaria and fetal growth, with broader topics such as interaction of nutrition and infection, and protein-calorie deficiency are followed by summaries of discussion sessions. The discussion sessions are one of the most attractive features of the book. Content of the papers presented at this symposium is viewed thoughtfully by the discussants from several points of view.

An introductory chapter describes the use of germ-free animals in determining contributions of intestinal flora to nutritional status, as well as in determining the less well understood parasite-host relationship.

Summaries of malnutrition problems and the incidence of infectious diseases in underdeveloped countries such as Nigeria, Guatemala and Ethiopia point out some of the difficulties in designing and executing nutrition studies in the field.

The theme of infantile and adult diarrheas, their causes and effects, is alluded to frequently. The role of environmental sanitation in their etiology is constantly stressed.

This book points up again the seriousness of malnutrition throughout the world. For that reason, as well as others, it is recommended reading.—ANNETTE GORMICAN, PHD

FROM AUSCULTATION TO PHONOCARDIOGRAPHY

By Aldo A. Luisada, M.D., Professor of Medicine and Professor of Cardiovascular Research, Chicago Medical School. C. V. Mosby Co., St. Louis, Mo. 1965. 351 pages. Price: $17.75.

This is an all inclusive dissertation of generally heart sounds and mainly phonocardiography, from the author's wide experience in this most interesting field. It enumerates the mechanism of heart murmurs, their interpretation including physiology, contributory phenomena, and offers a worthwhile more comprehensive system of evaluating clinical auscultation.

The author spends the major portion of his book detailing and illustrating phonocardiograms including its pitfalls and technical difficulties.

The material contained is worthwhile digesting by the internist, the cardiologist, and the teacher.—H. H. SHAPIRO, M.D.

DIAGNOSTIC PROCEDURES IN GASTROENTEROLOGY

Edited by Charles H. Brown, MD, Head, Dept. of Gastroenterology, Cleveland Clinic Foundation, Cleveland, Ohio. C. V. Mosby Company, 3207 Washington Blvd., St. Louis, Missouri 63103. 1967. 438 pages. Price: $19.75.

This book is dedicated to the present and future fellows in Gastroenterology at the Cleveland Clinic. It is designed to be a brief outline of the principles involved and all the procedures in Clinical Gastroenterology. Sixty-four procedures are briefly described. Discussions are too short for the physician to use this text as a definitive reference to prepare himself for performing a given procedure, yet the technical information given is more than would be required by the average general reader. Unfortunately, there is no more comprehensive text which could be recommended as a guide to the gastroenterologist and no more general coverage of the topic to be recommended to others. Doctor Brown provides references to classic articles describing each procedure. The final section of the text is a detailed description of the 27 diets used at the Cleveland Clinic. A number of recipes for the preparation of glutin-free meals are given. It is suggested that this book be available in the libraries of the larger hospitals and clinics.—JOHN F. MORRISSEY, MD □

the wisconsin medical journal

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Presidents and secretaries of the 54 component county medical societies are listed periodically.

MEDICAL MEETINGS
POSTGRADUATE COURSES

1969 WISCONSIN

Aug. 2–3: State Medical Society Council meeting.

Aug. 11–15: Fourth Workshop for the Treatment of Scoliosis and Round Back with the Milwaukee Brace and Exercises in the Brace, Orthopaedic Department of Marquette School of Medicine in cooperation with Milwaukee Children's Hospital, Milwaukee.

Sept. 4: Postgraduate course—The Dentist and Cancer Control, University of Wisconsin Medical Center, Madison.

Sept. 11–14: Annual Meeting, Wisconsin Society of Internal Medicine, Kaehlers Resort (formerly Uphoffs') Lake Delton (changed from Deer Park Lodge).

Sept. 14–16: Wisconsin Pharmaceutical Association 89th annual convention, Wisconsin Dells.

Sept. 26–28: Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Dell View Hotel, Lake Delton.

Sept. 27: Fifteenth annual fall cancer conference (Cancer Scrimmage—Wis. vs. UCLA), University of Wisconsin Medical Center, Madison.

Oct. 1: 4th annual Symposium of Adolf Gundersen Medical Foundation and Wisconsin Heart Association entitled "Acute Myocardial Infarction," La Crosse.

Oct. 3–4: Annual meeting, Easter Seal Society of Wisconsin, Beaumont Motor Inn, Green Bay.

Oct. 6–10: Wisconsin Work Week of Health, State Medical Society, to be held each day in a different city: Eau Claire, Wausau, Green Bay, Milwaukee, and Madison.

Oct. 8–9: Annual meeting, Wisconsin Academy of General Practice, Holiday Inn No. 2, Madison.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton–Schroeder Hotel, Milwaukee.

1969 NEIGHBORING STATES

Aug. 6–8: Seminar in Neurology, Neuroradiology, and Neurosurgery, Minneapolis VA Hospital, Minneapolis, Minn.

Aug. 10–15: American Congress of Rehabilitation Medicine, Chicago, Ill.

Aug. 17–22: American Congress of Physical Medicine and Rehabilitation, Chicago, Ill.

Aug. 18–21: American Hospital Association, Chicago, Ill.

Sept. 14–20: College of American Pathologists, Chicago, Ill.

Sept. 14–21: American Society of Clinical Pathologists, Chicago, Ill.

Sept. 15–16: Biennial meeting of State Medical Journal Advertising Bureau, Chicago, Ill.

Sept. 22–23: Midwest Interprofessional Seminar on Diseases Common to Animals and Man, Memorial Union, Iowa State University, Ames.

Oct. 4–10: Annual Otolaryngologic Assembly of 1969, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Oct. 10–11: American Society of Ophthalmologic and Otorhinolaryngologic Allergy, Chicago, Ill.

Oct. 11–12: American Association of Ophthalmology, Chicago, Ill.

Oct. 12–17: American Academy of Ophthalmology and Otolaryngology, Chicago, Ill.

Oct. 15: Fifth annual professional symposium on Recent Advances in Renal Disease, Kidney Foundation of Illinois, LaSalle Hotel, Chicago.

Oct. 16–17: American Association for Automotive Medicine, Mayo Auditorium, Minneapolis, Minn.

Oct. 18–23: Annual meeting, American Academy of Pediatrics, Palmer House Hotel, Chicago.

Oct. 29–30: American Association for the Study of Liver Disease, Chicago, Ill.

Oct. 29–Nov. 2: American College of Chest Physicians, Chicago, Ill.

Nov.: American Society of Therapeutic Radiologists, Chicago, Ill.

Nov. 2–5: International Symposium on Atherosclerosis, Chicago, Ill.

Nov. 3–14: Postgraduate course in Laryngology and Bronchoesophagology, Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago.

Nov. 8–9: North Central Medical Conference, St. Paul Hilton, St. Paul Minn.

Nov. 11–15: American College of Preventive Medicine, Detroit, Mich.

Nov. 21–22: Workshop on the Delivery of Medical Care in the 1970s, Institute of Medicine of Chicago, Ambassador Hotel, Chicago.

Nov. 28–29: Head and Neck Radiology Conference, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Nov. 30–Dec. 5: Radiological Society of North America, Chicago, Ill.

1969 OTHERS

July 7–11: Postgraduate Course—Clinical Electrocardiographic Interpretation Hahnemann Medical College and Hospital, Philadelphia, Pa.

July 14–18: Postgraduate course—Interpretation of Cardiac Arrhythmias, Hahnemann Medical College and Hospital, Philadelphia, Pa.

July 21–25: Postgraduate course on Internal Medicine, University of Colorado School of Medicine, YMCA Conference Center, Estes Park, Colo.

Aug. 11–15: American Bar Association, Dallas, Tex.

Aug. 11–16: General Practice Review, University of Colorado School of Medicine, Denver, Colo.

Aug. 11–17: Postgraduate course—Space Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 14–16: Postgraduate course on Peptic Ulcer, American Gastroenterological Association, Aspen, Colo.

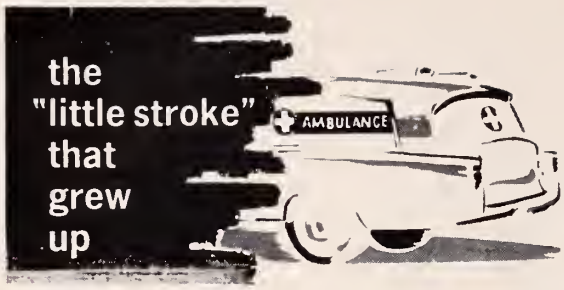
Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham Hotels, Washington, D. C. and Baltimore, Md.

Sept. 5–7: Cardiovascular Symposium, Tidewater Heart Association, Williamsburg, Va.

Sept. 8–12: Fifth International Congress of Dietetics and 52nd annual meeting of American Dietetic Association, Sheraton–Park Hotel, Washington, D.C.

Sept. 24–26: Cleveland Course in Pulmonary Diseases, Case Western Reserve University School of Medicine in cooperation with St. Luke's Hospital, American Thoracic Society, and others, Cleveland, Ohio.

Sept. 28–Oct. 3: Annual meeting Michigan State Medical Society, Detroit.



prevent the progression from "little strokes" to serious cerebral vascular accident with hescor

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Gale and Thewlis reported, "Many cerebral accidents may be avoided if adequate amounts of capillary protective factors — hesperidin complex and ascorbic acid are provided."[1]

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[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 7–11: Western Conference of Prepaid Plans, Sun Valley, Idaho.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 22–24: 16th Western Cardiac Conference, University of Colorado Medical Center, Denver, Colo.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

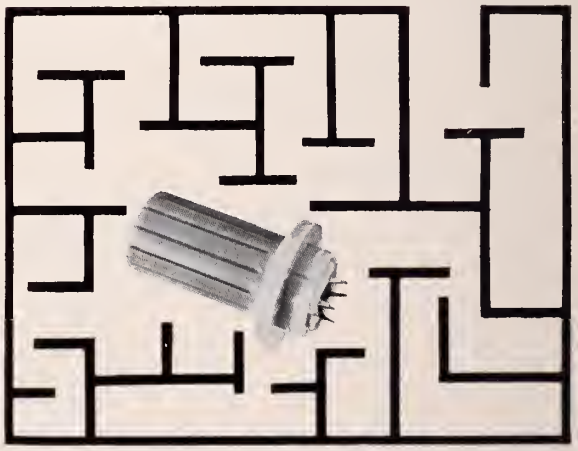
Nov. 12–15: Postgraduate conference, Mound Park Hospital Foundation and University of Florida, Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Nov. 20: Annual Membership Meeting, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium). Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psychosomatic Seminars), to South Pacific.



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1969 AMA

July 13–19: Annual meeting, American Medical Association, New York City.

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

May 11–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 NEIGHBORING STATES

Oct. 5–9: 53rd Annual Meeting, American Dietetic Association, Detroit, Mich.

1970 OTHERS

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1971 OTHERS

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the **Journal of the American Medical Association.**

General Practice Review—Colorado

The 15th annual postgraduate course designed especially for the general practitioner will be held Aug. 11–16 at Denver, Colo. Registration may be made for the entire course or for any selected days: Monday—Medicine; Tuesday—Pediatrics; Wednesday—Dermatology; Thursday—Surgery; Friday—Obstetrics and Gynecology; and Saturday—Trauma.

Contact: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Diabetes Detection—New York

The Disease Detection Information Bureau will sponsor a workshop on Diabetes Detection at the New York Hilton, New York City, Saturday, July 12, the day before the opening session of the American Medical Association's annual meeting.

Theme of the workshop is "Practical Planning for Community Screening Programs." The one-day meeting is designed to be a how-to-do-it short course for individuals interested in or involved in diabetes detection programs at the community level.

Attendance at the workshop is open to both professional and lay persons. There will be no registration fee and all registrants will be the guests of DDib at luncheon.

Advance registration required. Contact: Morton B. Stone, Workshop Coordinator, 3553 West Peterson Ave., Chicago, Ill. 60645.

Neural Science Seminar—Minneapolis

A Seminar in Neurology, Neuroradiology, and Neurosurgery will be held at the Minneapolis Veterans Administration Hospital Aug. 6–8. Recent advances in these fields will be reviewed.

Physicians and other medical personnel are invited to attend. Cost of the seminar will be borne by the VA Hospital, Minneapolis, Minn. Rooms have been reserved for visiting participants at a minimal cost at the Sheraton Motor Inn on Highway 494. A social program as well as the lectures by outstanding faculty is being planned. Registration may be made with Dr. Milton Alter, Chief of Neurology Service, Veterans Administration Hospital, Minneapolis, Minn. 55417.

Heart Symposium—La Crosse

The Adolf Gundersen Medical Foundation, La Crosse, and the Wisconsin Heart Association will hold their 4th annual symposium on Oct. 1 in La Crosse.

The subject this year is Acute Myocardial Infarction. As in the past this will be a one-day program from 9 in the morning until 4 in the afternoon with luncheon.

Speakers and their topics are as follows:

Colonel Robert J. Hall, MD, Chief, Cardiology Service, Walter Reed General Hospital, Washington, D. C., speaking on "Acute Myocardial Infarction—The Diagnosis."

Donald C. Harrison, MD, Associate Professor of Medicine, Stanford University School of Medicine, Palo Alto, Calif.; Chief, Division of Cardiology, Stanford University School of Medicine. His title: "The Use of Lidocaine for the Treatment and Prevention of Cardiac Arrhythmias Following Myocardial Infarction."

John P. Shillingford, MD, Professor of Angio-cardiology, Royal Postgraduate Medical School, London; Director of the Medical Research Council, Cardiovascular Research Unit. His title: "The Management of the Coronary Crisis."

Herman K. Hellerstein, MD, Associate Professor of Medicine, Western Reserve University; Chief of the Cardiology Outpatient Department, University Hospitals of Cleveland. Subject: "Exercise and Myocardial Infarction—Value and Limitations."

W. Gerald Austen, MD, Professor of Surgery, Harvard Medical School; Chief, Surgical Cardiovascular Research Unit, Massachusetts General Hospital. Subject: "Surgically Correctable Cardiac Complications of Acute Myocardial Infarction."

The afternoon session features a panel discussion with questions and answers from the audience.

All physicians are invited to attend. Registration fee is $5. Write to: A. Erik Gundersen, MD, Program Director, 1836 South Avenue, La Crosse, Wis. 54601.

Pulmonary Diseases—Cleveland

The Cleveland Course in Pulmonary Diseases will be held Sept. 24–26 at St. Luke's Hospital on Shaker Boulevard in Cleveland, Ohio.

The 1969 program, "The Clinical Application of Pulmonary Physiology," is aimed at updating internists, pediatricians, and thoracic surgeons in the principles of pulmonary physiology that would be helpful in the diagnosis and management of pulmonary diseases.

Subsequent courses in 1970 and 1971 will deal specifically with the treatment of ventilatory insufficiency, industrial lung diseases, and pulmonary infections.

Dr. Austin S. Weisberger, director of the Department of Medicine at Case Western Reserve University School of Medicine, and Dr. George W. Wright, head of Medical Research at St. Luke's Hospital, will direct the course.

An excellent faculty has been assembled from the hospital staffs in Cleveland and the visiting faculty will include Dr. Leon Fahri, professor of Physiology at the State University of New York at Buffalo School of Medicine, and Dr. Robert Hyatt, associate professor of Physiology at the Mayo Graduate School of Medicine.

Included in the three-day course are lectures, demonstrations, case presentations, and audience participation in clinical discussions.

The course is being sponsored by Case Western Reserve University School of Medicine, The Tuberculosis and Respiratory Disease Association of Cleveland and Cuyahoga County, The Ohio Tuberculosis and Health Association, and The American Thoracic Society.

Registration fee is $75 for ATS members and $100 for nonmembers.

Contact: Office of Continuing Medical Education, Case Western Reserve University School of Medicine, 2107 Adelbert Road, Cleveland, Ohio 44106.

Scoliosis and Round Back—Milwaukee

The Fourth Workshop for the Treatment of Scoliosis and Round Back with the Milwaukee Brace and Exercises in the Brace will be held from Aug. 11 to 15 by the Orthopaedic Department of Marquette School of Medicine as a part of the 75th Anniversary celebration of the Milwaukee Children's Hospital.

Teams including orthopaedic surgeons and orthotists should write for information to: Dr. Bruce J. Brewer, Chairman of the Orthopaedic Department, Marquette School of Medicine, 2040 West Wisconsin Ave., Suite 452, Milwaukee, Wis. 53233.

Internal Medicine—Colorado

A five-day postgraduate course on Internal Medicine will be held July 21–25 at the YMCA Conference Center in Estes Park, Colo., under sponsorship by the University of Colorado School of Medicine.

Separate days will be devoted to Dermatology, Endocrinology, Hematology, Infectious Diseases, and Pulmonary Diseases. Ample time will be provided for questions and discussion.

No formal meetings are scheduled for the afternoons so that this time may be used to enjoy the area and to engage in informal discussions with speakers and other registrants.

Tuition is $90 which includes a nonrefundable registration fee of $10. A certificate of credit for 20 hours will be provided to members of the AAGP upon request.

Contact: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Emergency Room Nurses—Chicago

The third annual Postgraduate Course for Emergency Room Nurses will be conducted Sept. 25–27 in the Palmer House Hotel, Chicago.

The three-day course will be held this year in the Palmer House to allow expansion of enrollment to 1,000 nurses, not only those assigned to hospital emergency rooms but also nurses who meet emergency injury situations in their affiliations with industry and schools, according to Dr. George Anast, program chairman.

Distinguished specialists will comprise the faculty for a curriculum which will include formal lectures, audio-visual presentations and a series of seminars to give nurses an opportunity to pursue various subjects of particular interest.

Advance registration is required and should be accompanied by the tuition fee of $60 which covers three full days of scientific sessions and the chairman's reception and banquet. Registration fees and inquiries may be addressed to Dr. Anast at 55 East Washington Street, Chicago, Ill. 60602.

The Emergency Room Nurses program is one of four courses annually sponsored as a public service by the Chicago Committee on Trauma of the American College of Surgeons.

Cardiovascular Symposium—Virginia

The tenth annual Cardiovascular Symposium of the Tidewater Heart Association will be held in three half-day sessions Sept. 5–7 at The Williamsburg Lodge and Conference Center, Williamsburg, Va.

Registration fee: $25. Acceptable for 10 prescribed hours credit by the AAGP. A generous amount of free time has been scheduled in order to give registrants and families an opportunity to investigate the 18th Century charm of Colonial Williamsburg. Contact: Tenth Annual CV Symposium, Tidewater Heart Association, 523 Boush Street, Norfolk, Va. 23510.

Automotive Medicine—Minneapolis

The American Association for Automotive Medicine will convene Oct. 16–17 in Minneapolis at the Mayo Auditorium. Members will be guests of the Department of Postgraduate Education of the University of Minnesota.

Program will stress pre-crash medical aspects of highway safety. For further details contact: Merrill Cragun at the University of Minnesota or J. L. Weygandt, MD, AAAM Secretary, Sheboygan Falls.

Mound Park Hospital—Florida

The Mound Park Hospital Foundation with the joint sponsorship of the University of Florida's J. Hillis Miller Health Center is holding its Third Annual Postgraduate Conference on "Today's Hospital Problems: An Interdisciplinary Approach" on Nov. 12–15 at the Tides Hotel and Bath Club in Redington Beach, Fla.

As in the past this postgraduate conference will be completely comprehensive and designed specifically for physicians who hold hospital staff leadership positions, hospital administrators, hospital trustees, and such allied personnel selected by hospital administration and division chiefs.

This program is acceptable for 20 accredited hours by the AAGP. The teaching faculty will be composed of selected guest lecturers and an expert staff from the University of Florida and the Foundation.

Fee: $100. Contact: Postgraduate Medical Education, Mound Park Hospital Foundation, 701—6th Street South, St. Petersburg, Fla. 33701.

American Academy of Pediatrics

In depth presentations on child care—a national challenge, new considerations in the diagnosis and management of neonatal jaundice, key issues in infant mortality, multiphasic screening for pediatric patients, and current developments in objective means of diagnosis and therapy in allergic disorders, will be discussed during the 38th annual meeting of the American Academy of Pediatrics in Chicago, Oct. 18–23, in the Palmer House Hotel.

Additional timely scientific subjects will be presented during meetings of the Sections on Allergy, Anesthesiology, Cardiology, Child Development, Diseases of the Chest, Military Pediatrics, Pediatric Pharmacology, Public Health Pediatrics, and Surgery.

The meeting will also feature numerous seminars, round tables, and a full schedule of motion picture films.

A special one-day conference for pediatricians and pediatric nurses will be held also during the annual meeting. This conference will enable pediatricians and nurses to discuss cooperative approaches and potential programs for meeting patient care needs.

Hospital conferences at the Loyola University School of Medicine, the Michael Reese Hospital, and the University of Illinois School of Medicine, will be held on Thursday afternoon, Oct. 23. □

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Report on 1969 House of Delegates Session; Dr. Callan Installed; Dr. McRoberts Elected

The incoming president of the State Medical Society issued a warning that "the rising costs of quality medical care could possibly price it off the market for many people."

Speaking at the first session of the House of Delegates, Dr. Robert E. Callan, Wauwatosa, said:

"While we doctors are primarily concerned with our patients' medical needs, we must in these inflationary times particularly, act as wise conservators of health resources wherever possible, consistent with sound patient care.

"The individual physician is in the best possible position to help his patient make the most of whatever economic resources are available to him—whether they be in the form of cash, insurance, prepayment, or taxes."

While directing attention to the younger generation, Dr. Callan called for a "thorough study of senescence." "We cannot slight our aging patients, nor can we accept their indiscriminate banishment to bigger, better but more impersonal nursing and custodial institutions as a solution."

A THREESOME HEADING THE SOCIETY—Drs. J. W. McRoberts, Sheboygan, president-elect; R. E. Callan, Milwaukee, president; and W. D. James, Oconomowoc, immediate past president.

ANNUAL MEETING ATTENDANCE UP

Physician attendance at the Annual Meeting of the State Medical Society in Milwaukee, May 12–15, was substantially higher this year than last.

Total attendance for the session was 2,593, of which 1,430 were members of the Society.

Other attendance was made up of nurses, interns, residents, medical students, and other guests.

Dr. McRoberts: President-elect

Dr. Jerry W. McRoberts, Sheboygan, was elected to the post of president-elect of the State Medical Society at its 128th meeting in Milwaukee, May 12–15.

A surgeon, Dr. McRoberts will take office next May. He has been a member of the Society's Council from the Fifth District.

continued on page 47

Dr. James Urges Effective Utilization

"The most important contribution that physicians can make toward reducing the mounting costs of medical care is effective utilization review," declared Dr. W. D. James, Oconomowoc, out-going president of the State Medical Society.

In remarks to the House of Delegates, Dr. James said, "Too many patients are being kept in acute hospital beds or in extended care facilities for too long a period of time. Too many patients are getting specialized treatments without meaningful results."

continued on page 47

Commend Officers; Act on Nursing Home Units; Urge Support for Implied Consent Law

THIS ISSUE of the *Green Sheet* will replace the formal "Reports and Proceedings of the Annual Session of the House of Delegates" which in recent years has been printed as a special supplement to the *Wisconsin Medical Journal* at a cost of several thousand dollars. Members of the Society may, upon request, study the Official Transcript of the meeting at the State Medical Society Headquarters in Madison.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

The House, on the basis of a report of the Reference Committee on Reports of Officers, took the following actions:

- PRESIDENT'S REPORT—The House commended the report of President W. D. James and emphasized his recommendation "with respect to the provision of health care on the basis of true medical needs of patients and that this should be under the direction of the physician in order to conserve the health care dollar. This can best be accomplished by effective utilization review."

- PRESIDENT-ELECT'S REPORT—Commendation was given the report of President-Elect R. E. Callan, which "stressed proper utilization of health resources and recommends more intensive study regarding the true problems of the aging and how best to meet them."

- WOMAN'S AUXILIARY—The House complimented the Auxiliary for its activities, especially the "fine promotion of the Work Week of Health."

- COMMISSION ON STATE DEPARTMENTS—The House accepted the report of this Commission and 8 of its 10 Divisions. It pointed out that the Commission coordinates the activities of the Divisions so that the Society can be of utmost assistance to the various state agencies that have responsibilities in health matters.

The House accepted and adopted the reports of the following Divisions of the Commission:

Aging: Special note was taken of the need for physicians to determine the medical and ancillary care needed by each patient. It also recommended that in the composition of advisory committees to nursing homes the membership of these committees be determined locally within the resources of the county society.

Alcoholism and Addiction: Accepted the report and requested this Division to "review separately" several proposals relating to alcohol services "before any final action can be recommended." This involves about 20 proposals for improving the prevention, treatment, and control of alcoholism in Wisconsin. The recommendations are to be made to the Board of Health and Social Services of the State of Wisconsin.

Ear, Nose and Throat: Accepted the report, and asked that the Division continue to work with the Society's Commission on Public Policy concerning the possible licensure or certification of hearing aid dealers.

Handicapped Children: Accepted the report (dealing especially with the establishment of pediatric clinics through the Bureau for Handicapped Children of the State Department of Public Instruction), and urged the state department to make the clinic services available on the basis of need. It also expressed the hope that these (clinics) would be coordinated with policies determined by the medical society in the area involved.

Maternal and Child Welfare: Accepted the report, as well as the report of its Subcommittee on Maternal Mortality, and commended Dr. John R. Evrard, Milwaukee, retiring chairman of the Division. The Division is studying legal aspects of the examination and treatment of minors for

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1969 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

SOME OF THE 140 DELEGATES AND ALTERNATES ATTENDING THE ANNUAL SESSION OF THE HOUSE

VD without parental consent. It recommends amalgamation of obstetrical units in hospitals which have below optimum number of deliveries where such amalgamation and coordination is feasible for the patient.

Nervous and Mental Diseases: Accepted the report, and recommended that the Division continue its sponsorship of educational symposia. The Division has been active in the recodification of the state's mental health laws, and is making efforts to improve care in county hospitals.

Rehabilitation: Adopted the report, and noted the necessity to maintain surveillance over the services and use of the facilities which are at times ordered in the name of the physician. It also urged that membership of any advisory committee to nursing homes be composed within resources available in the county medical society.

School Health: Reviewed the report, and urged the Commission on State Departments to evaluate carefully each part of the proposed "Guide—School Health Examinations" before final publication. It asked that special attention be given to the legal basis and the true purpose of school health examinations, "bearing in mind the privileged and confidential nature of personal health records." It emphasized that "the proper role of the physician is that of a medical advisor and the responsibility of whether an athlete participates in competitive sports is primarily that of the parent or guardian." It asked that information on an AMA weigh-in plan for wrestling be related to all members of the Society by the delegates.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Drs. W. D. Hamlin, Mineral Point, chairman; R. D. Heinen, Oconto; C. J. Strang, Barron (left to right above), and Drs. Anne Roethke and W. L. Coffey, Milwaukee (absent at time of picture).

REPORT OF REFERENCE COMMITTEE ON STANDING COMMITTEES

The following is a summary of the actions of the House of Delegates based on the report of the Reference Committee on Reports of Standing Committees:

- SAFE TRANSPORTATION—The report was accepted, and all members of the Society were urged to contact their legislators in support of Senate Bill 219 which would enact an "implied consent" law previously supported by the SMS House of Delegates. It also urged the legislature to pass a law implementing the use of the "Slow Moving Vehicle" sign in Wisconsin.

- MEDICAL PRACTICE ACT—Adopted the report of the Ad Hoc Committee on the Medical Practice Act, commending several proposals to amend the act to help relieve the physician shortage in Wisconsin. It urged the committee to complete a study dealing with voluntary certification of groups ancillary to medicine.

- STATE LEGISLATION—Adopted the report of the Society's Commission on Public Policy which reviewed several bills now pending in the state legis-

Urge Additional Donations to Student Loan Fund

lature. The House took special note of the Society's proposal to introduce legislation authorizing the Medical Examining Board to provide medical scholarships from any excess registration fees which are not used in administration. It was felt that this is a more equitable use of the funds than allowing them to lapse into the general funds of the state. The House also encouraged support for the enactment of a Uniform Anatomical Gifts Act.

● HOSPITAL RELATIONS AND MEDICAL EDUCATION —Adopted this report, and supported proposals calling for the Joint Commission on Accreditation of Hospitals to complete its revisions of standards as soon as possible, and that it accept as its responsibility the classification of hospital emergency room facilities. The House also urged the establishment by the CES Foundation of a post-baccalaureate fellowship fund for potential medical students in memory of George W. Hilliard, MD, Milwaukee, "who gave so generously of his time and service to the State Medical Society."

● HEALTH INFORMATION—Adopted the report, and agreed that the "Guide for Physicians, Hospitals and News Media" be revised and made available to all members as soon as possible, and that county medical societies be encouraged to establish advisory committees on industrial health needs.

● HEALTH AND NATURAL RESOURCES—Accepted the report, urging that the Division of Health of the State Department of Health and Social Services use the fecal coliform testing program for swimming water rather than the E. coli test, (just as does the State Laboratory of Hygiene) and that the state division explore and implement new testing techniques for other bacterial and chemical pollutants. In addition the House urged the division to establish closer communications with practicing physicians on the subject of testing swimming water.

● MEDICINE AND RELIGION—Accepted the report, and recommended contacts with theological schools in Wisconsin to determine which are interested in help from the Society in teaching their students. It also urged more publicity in the *Wisconsin Medical Journal,* and encouraged county medical societies to establish programs on religion and medicine.

● CES FOUNDATION—Accepted the report and commended the Charitable, Educational and Scientific Foundation of the Society for its activities in scientific programming and the operation of the medical student loan fund.

In addition, the House adopted Resolution K which reported the great demand for loans has exhausted the CES Foundation loan fund. As a result 25 to 30 needy and deserving students, some in pressing circumstances, cannot be assisted for the current and upcoming semesters at both Marquette and UW medical schools. The House therefore adopted Resolution K as follows:

> "*Resolved,* that although many may already have made donations earlier this year, each member of the State Medical Society be urged to contribute as soon and as generously as possible to the CESF medical student loan fund so that loan assistance may be made available to those students who most urgently need it at this time."

● MILITARY SERVICE—Accepted the report which indicated that 70 cases of physicians eligible for the draft were reviewed in the past year.

REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Eleven resolutions and several other matters were considered by the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws. Based on its report, the House took the following actions:

● SITE OF ANNUAL MEETING—Resolution A, introduced by the La Crosse County Medical Society, proposed that the Annual Meeting be held in a city other than Milwaukee every third year, and extended an invitation to meet in La Crosse. The House did not adopt the resolution, but referred it to the Commission on Scientific Medicine for its future consideration. The House noted and accepted a report of the Council committing the meeting to Milwaukee through 1974.

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Drs. K. L. Siebecker, Madison; W. F. Henken, Racine, chairman; Henry Asche, Minocqua; R. F. Lewis, Marshfield; and A. J. Sanfelippo, Milwaukee (left to right).

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Drs. S. J. Graiewski, Oshkosh; G. J. Derus, Madison, chairman; P. G. LaBissoniere, Wauwatosa; A. A. Drescher, Menomonie; and J. M. Guthrie, Green Bay.

Seek Expansion of Family Medicine Programs

● MEDICAL EDUCATION—Resolution B, introduced by the Fond du Lac County Medical Society, proposed that "we do away with present thoughts of developing paramedical personnel and concentrate our efforts on the production of such primary physicians, who can practice under supervision after six years education and qualify for their MD degree, but who can—if he so desires—specialize with additional training; that we make full use of all existing medical facilities and talents so as to expedite the program, recognizing we have neither the time nor the money to accomplish our needs by any other course of action." The House did not adopt this resolution, but instead made three recommendations which were adopted:

1. The Council has an obligation to keep the membership posted on the ultimate outcome of special studies that are presently being carried on as a result of the Conference on Physician Shortage held in December 1968.
2. This special committee of the Council engage actively in conferences with the two medical schools to explore further the possibilities of curriculum changes with a view to more rapid production of the necessary physicians to meet the critical shortage.
3. That the usefulness and legality of paramedical personnel and their proper place in the delivery of health care has not been fully explored and definitive action at this time should be delayed.

● MEMBERSHIP—Resolution C, introduced by the Dodge County Medical Society, asked for a change in constitution and bylaws to permit a county medical society to accept a fully accredited physician as a member without his simultaneous membership in either the SMS or the AMA. The House rejected this resolution "because it is inconsistent with the goals and aims of your medical society."

● GENERAL PRACTICE—Resolution D, introduced by the Richland County Medical Society, proposed that the SMS recommend to the Board of Regents of the UW and Marquette medical schools the immediate development of Departments of General Practice in each school, and that all graduates of the UW medical school attend a three-month preceptorship with a general practitioner in the state prior to graduation. The House accepted the resolution in modified form, changing the resolves to read:

> *Resolved,* That the House of Delegates of the State Medical Society of Wisconsin recommend to the Board of Regents of the University of Wisconsin the continual development and expansion of existing programs in family medicine, and that the Marquette School of Medicine strive to develop a comparable program; and be it further,
>
> *Resolved,* That the recommendation be made that all graduates of the University of Wisconsin Medical School and Marquette School of Medicine have the opportunity to participate in a preceptorship experience with a general practitioner in the state prior to graduation.

● CHIROPRACTIC—Resolution E, introduced by the Richland County Medical Society, proposed that the State Board of Medical Examiners employ more investigators so that more adequate control may be exerted and more adequate supervision be made over the cult of chiropractic. The House adopted a substitute resolve on this matter:

> *Resolved,* That the House of Delegates of the State Medical Society of Wisconsin recommend that physicians in the state become more aware of violations of the Medical Practice Act and report such improper practices to the authorities so that the citizens of Wisconsin can be better protected against the members of this cult.

● COMMERCIAL LABORATORIES—Resolution F, introduced by the Section on Pathology, and Resolution J, introduced by the Council, dealt with the subject of commercial laboratories. Resolution F cited action by the AMA Board of Trustees to open all AMA publications to solicitation and commercial

Endorse Family Life, Sex Education in Schools

advertising of pathology by lay corporations. The House adopted Resolution F which stated:

Therefore: Be it resolved by the Section of Pathology of the State Medical Society of Wisconsin that the Section of Pathology

1. reaffirms medicine's traditional opposition to the practice of medicine by lay corporations and to solicitation and to commercial advertising of the practice of medicine, and
2. requests that the State Medical Society of Wisconsin House of Delegates oppose this AMA Trustee policy vigorously at the convention of the State Medical Society of Wisconsin in Milwaukee in May 1969, and
3. requests these delegates to call on the Wisconsin delegation to the AMA to reverse this Trustee policy at the AMA convention to be convened in July 1969 in New York City.

Resolution J was adopted in its entirety as follows:

WHEREAS, it is unethical to solicit physician referral for any services in the practice of medicine; and

WHEREAS, the solicitation of such medical services by salesmen or advertising for any physician constitutes a breach of ethics; and

WHEREAS, commercial laboratories are known to use salesmen's services and to advertise to acquire physician referral of laboratory tests; and

WHEREAS, certain commercial laboratories use physicians as nominal or real directors, and certain of these physicians willingly sell their services through sales persons and advertising; therefore be it

Resolved, that physicians who conduct themselves in this manner are to be censored as unethical.

● GROUP LIABILITY INSURANCE—Resolution G, introduced by the Kenosha County Medical Society, asked for a study of the feasibility of group professional liability insurance for the membership of the Society. The House adopted a substitute resolution as follows:

Resolved, that the House of Delegates of the State Medical Society of Wisconsin request the Council to explore and investigate the feasibility of applying the principles of group insurance coverage for professional liability (malpractice) insurance for its membership with the aim to reduce the high cost of this coverage when purchased on an individual basis; and be it further

Resolved, that further investigation be made by the Council of the feasibility of a panel system to handle groundless suits in an effort to avoid compromise settlements.

SOME NEW COUNCILORS—Drs. Thomas Foley, Milwaukee, 12th district; Walter F. Smejkal, Manitowoc, 5th district; J. W. McRoberts, Sheboygan, president-elect; and Howard Mauthe, Fond du Lac, 6th district.

● CIGARETTE ADVERTISING—Resolution H, introduced by the Oconto County Medical Society, called upon the AMA to favor banning cigarette advertising in and on the communications media. The House commended the *Wisconsin Medical Journal* and the *JAMA* for discontinuing cigarette advertising and adopted a substitute resolution stating "that efforts be exerted by the AMA to discourage the glorification of cigarette smoking in and on the communications media."

● REPORT OF THE COUNCIL—The report of the Council, including a membership and necrology report, was adopted by the House. At the same time, the House adopted an amendment of Chapter XI, Section 3, paragraph five of the Bylaws by addition of the following sentence: "Such resident members shall have the right to vote and hold office." The effect of this action is to encourage the interest and participation of hospital resident and research fellow members by giving them the right to vote and hold office. In so doing, however, they will not be included in the count of full-paid members in determining the number of delegates from a particular county medical society in the House of Delegates.

● SEX EDUCATION—Resolution I, submitted by the Council for the Trempealeau–Jackson–Buffalo Counties Medical Society, resolved "That the State Medical Society does approve of and encourage proper instruction in family life and sex education within the total (K–12) education of the child." The reference committee recommended rejection of the resolution, but the House overruled the recommendation and adopted the resolution without change.

● MEDICAL HISTORY—A supplementary report of the Council recommended and the House adopted an amendment of Chapter XII of the Bylaws to change the name of the Section on Medical History to "The Academy of Medical History."

REFERENCE COMMITTEE ON FINANCE—Drs. A. H. Stahmer, Wausau; R. L. Beilman, Madison; S. E. Zawodny, Milwaukee, chairman; J. G. Bergwall, Hortonville; and W. G. Kendell, Fond du Lac (left to right).

Endorse Charge Card; Review Society Finances

● RESOLUTION J OF 1968—The Council reported that, in reference to Resolution J of the 1968 Session of the House of Delegates, it had carried on correspondence with the Division of Health of the State Department of Health and Social Services. The division has stated that it acts as an agent of the Social Security Administration and must carry out its contractual obligations in accordance with the provisions of the contract and the regulations pertaining to the certification of independent laboratories under the Medicare Act. The reply was forwarded to the Section on Pathology, and the Council reported its belief that it had discharged its function on this matter.

The House adopted the reference committee report which suggested that "in the absence of an adequate and proper solution, the Council be further instructed to carry on investigation and study as it relates to the conflict between the Health Insurance for the Aged regulations and the practice of medicine in Wisconsin, and requests that the Council report to the House of Delegates in 1970 on this and other government regulations as they involve or conflict with the private practice of medicine."

● NOMINATING COMMITTEE—A resolution, introduced by the Speaker of the House, Dr. G. A. Behnke, Kaukauna, proposed that no member of the Nominating Committee could stand for election. The House rejected the resolution as one that "would not serve the best interests of our Society, and is in conflict with Robert's Rules of Order."

● SCIENTIFIC MEDICINE—The House accepted the report of the Commission on Scientific Medicine. In doing so, it called attention to the fact that the Commission, as charged by the House in 1968, had reviewed the format of the Annual Meeting and the feasibility of charging a registration fee to physicians. It had urged that consideration be given by the House to financing the Annual Meeting from the dues structure of the Society. The Council, acting on this recommendation, approved continuation of the present method of obtaining financial support from exhibitors at least through 1974.

REPORT OF REFERENCE COMMITTEE ON FINANCE

The House of Delegates, on the basis of the Treasurer's Report, various financial statements, and reports from the Commission on Medical Care Plans, took the following actions:

● REFERENCE COMMITTEE ON FINANCE—The House "felt it desirable that the Speaker appoint the House of Delegates Finance Reference Committee at the earliest possible opportunity." It further recommended that "subsequent to its appointment the House Finance Committee request the privilege of meeting with the Finance Committee of the Council at any of its meetings prior to the Annual Meeting." The House noted the new procedure of the Council Finance Committee to meet quarterly to review budget performance, and "requests that the House committee receive this same information."

● HEALTH CARE CHARGE CARD CORPORATION—The House adopted the reference committee report stating:

"There were a number of appearances on the Supplementary Report of the Commission on Medical Care Plans which related to the Charge Card Corporation. In addition, the committee reviewed the AMA action of June 1968, with regard to prepayment and postpayment health care financing and other communications expressing encouragement and enthusiasm for the Charge Card program. Your reference committee points out that the Charge Card Corporation is separately incorporated and is now in operation on an experimental basis. It also points out that the operation of the program does not involve the dues structure, and hopefully will render a necessary service to the public."

● COMMISSION ON MEDICAL CARE PLANS—The report of the Commission and its operating statement were reviewed in detail by the reference committee. It emphasized that the reserves of WPS for 1967 and 1968 were adjusted because "a number of Medicare Plus-15 claims for 1967 were not then known or filed for payment until 1968." The House adopted the reference committee report as a whole

complimenting the Commission and the staff "for their diligent interest and attention to the health needs of the citizens of Wisconsin, and voluntary health insurance in general."

● INVESTMENTS—The reference committee reported, and the House accepted, a detailed discussion of the Society's investment portfolio provided by investment counsel, and the recommendation to the Council and staff that "at appropriate intervals it review the investment portfolio particularly as to the balance between stocks and bonds, to be assured the Society is receiving full benefit from its investments."

● SMS DUES—The House accepted the reference committee report as follows:

> "Next your committee reviewed the SMS Operating Budget for 1969, with special concern for increased costs. It reports that special staff efforts are being made to reduce costs in areas where it is possible to do so. An example is that of the *Wisconsin Medical Journal* where an attempt is being made to cut down on costs where this can be done without destroying its value. This year, the House transactions will be summarized, rather than printed in their entirety. It is recommended that attention be given to reimbursement for certain additional services or work performed on behalf of section or specialty groups or other ancillary organizations, and the establishment of a policy to this effect.
>
> "After long discussion, and with the knowledge that there is not only a current deficit in the SMS budget, but the definite possibility of future deficit which could deplete the capital reserve to less than 25%, your committee feels that a dues increase is necessary, and strongly recommends approval to the increase of $25 for 1970 as suggested by the Council in its report to you."

● TREASURER—The House commended the treasurer, Dr. F. L. Weston, Madison, for "his diligence in supervision of the financial activities of the Society," and expressed its appreciation to staff and consultants for their availability for clarification and advice.

Woman's Auxiliary Is Major Asset to Society Programs

IN ADDRESSING the Society's House of Delegates during the Annual Meeting May 12–15 in Milwaukee, Mrs. James Sargent of Milwaukee, retiring president of the Woman's Auxiliary to SMS, outlined the following major accomplishments of the Auxiliary during her term in office:

● HANDLED the promotional activity of the 1968 Work Week of Health—"Youth on a Four-Day Trip"—with attendance soaring to a record high of nearly 3,400 high school students and others.

Mrs. James Sargent

Mrs. William Smollen

● SPONSORED a Health Careers Day at SMS headquarters in Madison to which a capacity attendance of 400 high school students from the entire state was recorded.

● ASSISTED locally in community-sponsored Health Careers Days; five county medical auxiliaries sponsored their own.

● SET UP meals service, home nursing, and friendly visitor projects in several county auxiliaries.

● ASSISTED with blood donor and various health screening or immunization programs.

● GAVE nearly $18,000 in county and state scholarships or loans in all fields of medicine.

● UNDERTOOK assorted activities in mental health.

● DONATED more than three tons of pharmaceuticals, bandages, soap, sheets, and hospital gowns and equipment for International Health.

● PARTICIPATED in legislative activities and held a Legislative Day.

● GAVE $500 to the Society's CES Foundation.

● HELPED with the CES Foundation's Christmas Card project.

● GAVE $100 each to the University of Wisconsin and Marquette WASAMA—Woman's Auxiliary to the Student American Medical Association—chapters.

● ASSISTED their local county and the State medical societies in special programs.

During the business affairs of the Auxiliary's annual meeting, Mrs. William Smollen of Racine was installed as the new president. Mrs. Dale Moen of Shell Lake was elected president-elect; Mrs. D. G. MacMillan, Barron, vice-president; Mrs. Robert Schmidt, Green Bay, recording secretary; and Mrs. Robert Cullen, Fond du Lac, treasurer. New directors for a two-year term are: Mrs. William Chandler, Appleton; Mrs. M. F. Stuessy, Platteville; and Mrs. Harold Breier, Montfort.

THE FOLLOWING FINANCIAL STATEMENTS are a part of the Annual Certified Audits prepared by Donald E. Gill & Company, certified public accountants, and reflect the general financial condition of the Society at Dec. 31, 1968. ■ Audit reports were prepared for the State Medical Society of Wisconsin and its related organizations: Wisconsin Medical Journal, Wisconsin Physicians Service, Civilian Health and Medical Program of the Uniformed Services, Supplemental Medical Insurance Benefits for the Aged, Wisconsin Medical Assistance Program, SMS Realty Corporation, Charitable, Educational and Scientific Foundation, Inc., Student Loan Fund, Employees' Pension Plan and Trust Agreement, and WPS Charge Card Corporation. ■ These reports, in their entirety, may be reviewed by members upon request to the State Medical Society office.

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund
Madison, Wisconsin

BALANCE SHEET
December 31, 1968

ASSETS		
Current Assets		
Cash	$109,357.72	
Accounts Receivable—General	2,187.15	
Due from Employees	989.41	
Due from Charitable, Educational and Scientific Foundation, Incorporated	9,272.66	
Due from SMS Realty Corporation	6,404.11	
Due from Wisconsin Medical Journal	1,397.57	
Due from Wisconsin Physicians Service	60,005.74	
Due from WPS Charge Card Corporation	6,732.83	
Investments	8,412.50	
Accrued Dividends Receivable	25.00	
Guaranty Deposit	425.00	
Unexpired Insurance	1,144.68	
Total Current Assets		$206,354.37
Long Term Assets		
Loan Receivable		20,000.00
Capital Invested in Divisions		
Wisconsin Medical Journal		9,766.83
Fixed Assets		
Furniture and Equipment	$ 42,465.21	
Less: Accumulated Depreciation	31,509.27	
Total Fixed Assets		10,955.94
Prepaid Expenses and Deferred Charges		
Prepaid Postage and Deposits	$ 7,053.97	
Inventory of Forms and Office Supplies	7,167.62	
Other Deferred Expense	2,666.69	
Total Prepaid Expenses and Deferred Charges		16,888.28
TOTAL ASSETS		$263,965.42
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable	$ 19,209.48	
Due Employees	1,533.53	
Dues Held for Section on Ophthalmology	8,995.91	
Accrued Payroll Taxes	32,032.57	
Accrued Property Taxes	11,263.10	
Accrued Employees Insurance	2,610.97	
Total Current Liabilities		$ 75,645.56
Deferred Income		
Prepaid Membership Dues	$113,191.00	
Other Prepaid Income	12,388.50	
Total Deferred Income		125,579.50
Total Liabilities		$201,225.06
Net Worth		
Capital of General Fund—1/1/68	$109,169.68	
Deductions		
Decrease in Capital Invested in Wisconsin Medical Journal	$ 9,705.02	
Excess—Expense Over Income—1968	36,724.30	
Total Deductions	46,429.32	
Total Capital—12/31/68		62,740.35
TOTAL LIABILITIES AND CAPITAL		$263,965.42

NOTES:
(1) Reserves of Wisconsin Physicians Service, a division of the State Medical Society of Wisconsin, are not included in this statement.
(2) The interest in SMS Realty Corporation is not carried as an asset of the General Fund.

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSES
Year Ended December 31, 1968

INCOME			
Members' 1968 Dues			$439,544.00
Members' Dues—Prior Years			1,280.00
Dues—Section on Medical History			1,220.00
Annual Meeting			30,167.00
Administrative Services			5,197.95
Miscellaneous Income			(507.75)
Income on Funds Invested			4,815.47
Gain on Disposal of Fixed Assets			109.50
TOTAL INCOME			$481,826.17
EXPENSE			
Payroll	$220,279.53		
Less: Payroll Recovered	19,224.86	$201,054.67	
Insurance—Employees		7,328.05	
Retirement Plan Contribution		12,504.70	
Payroll Taxes		7,814.43	
Conference Expense		47,879.71	
Association Dues		2,242.28	
Travel Expense—Staff		25,420.05	
Telephone		1,852.98	
Resource Material		1,057.14	
Printing and Forms		26,531.48	
Postage		11,730.08	
Office Supplies		2,356.06	
Promotion		14,750.97	
Insurance—General		2,833.20	
Grants and Appropriations		29,151.00	
Cafeteria Expense		2,083.62	
Speakers Expense		7,347.66	
Outside Services		21,542.82	
Miscellaneous Expense		5,466.75	
Auditing and Accounting Consultation		4,989.90	
Legal Counsel		17,064.33	
Legislative Retainer		13,220.00	
Depreciation		2,672.45	
Rent—Central Office		59,738.54	
Rent—Other		2,100.00	
Rental of Equipment		4,574.30	
Equipment Repair and Maintenance		672.20	
Personal Property Tax		959.62	
Total		$536,938.99	
Less: Portion of above Expenses Recovered by Services Furnished to Others		20,373.65	
TOTAL EXPENSES			516,565.34
Excess—Income over Expense Before Special Item			($ 34,739.17
Special Item			
Transfer of Occupational Health Guides to Charitable, Educational and Scientific Foundation, Incorporated			$ 1,985.13
Excess—Income over Expense			($ 36,724.30)

NOTES:
(1) The above excess of expense over income for 1968 is closed to Net Worth accounts as follows:

To Reserve for Budget Carryovers	$ 3,951.00
To Unappropriated Surplus	(41,860.66)
Total—General	($ 37,909 66)
To Section on Medical History	1,185.36
Total	($ 36,724.30)

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund

Madison, Wisconsin

ANALYSIS OF CAPITAL

Year Ended December 31, 1968

	Capital Surplus	Medical History	Wisconsin Medical Journal	Budget Carry-overs	Unappro-priated Surplus	Total
Balance—January 1, 1968	$5,478.97	$4,120.26	$19,471.85	$2,762.00	$77,336.60	$109,169.68
Additions						
Decrease in Capital of Wisconsin Medical Journal			(9,705.02)			(9,705.02)
Excess of Medical History Dues over Expenses		1,185.36				1,185.36
Excess of General Expense over Income					(37,909.66)	(37,909.66)
Transfers				3,951.00	(3,951.00)	
Balance—December 31, 1968	$5,478.97	$5,305.62	$ 9,766.83	$6,713.00	$35,475.94	$ 62,740.36
Detail of Budget Carryovers						
Open Panels				$4,761.00		
Town and Gown Symposium				1,952.00		
Total				$6,713.00		

STATE MEDICAL SOCIETY OF WISCONSIN AND RELATED ORGANIZATIONS

Madison, Wisconsin

CONSOLIDATED BALANCE SHEET

December 31, 1968

ASSETS		
Cash	$ 1,236,674.51	
Current Receivables	2,771,617.32	
Invested Funds, Accrued Interest and Dividends Receivable (Note 1)	13,162,191.04	
Student Loans Receivable and Accrued Interest	177,668.70	
Land, Buildings, Equipment and Vehicles—Net Book Value (Note 2)	1,781,499.17	
Organization Expense	1,004.35	
Prepaid Expense and Deferred Charges	185,863.29	
Deposits	863.82	
Long Term Receivables	20,000.00	
TOTAL ASSETS		$19,337,382.20
LIABILITIES, RESERVES AND CAPITAL		
Current Payables, Other Than Benefits	$ 503,944.27	
Mortgages and Debentures Payable	32,500.00	
Deposits Held	92,791.84	
Old Outstanding Checks	20,253.33	
Benefits Payable	8,484,585.35	
Unearned Income	3,654,857.30	
Reserves of Medical Care Plans	5,244,804.82	
Total Liabilities and Reserves	$18,033,736.91	
Net Worth of General Fund	62,740.36	
Capital of SMS Realty Corporation	345,548.30	
Restricted Principal of Funds	895,356.63	
TOTAL LIABILITIES, RESERVES AND CAPITAL		$19,337,382.20
CONTINGENT LIABILITIES		
Contractual Future Adjustment of Income Under Federal Employee Program		See Note 3

Notes one to five inclusive which follow are an integral part of this Balance Sheet.

NOTES

1. Invested funds shown above are included in some cases at book value and in others at market value. In the case of the Pension Plan values on the books are adjusted annually to market values in accordance with provisions of the Trust Agreement. In the case of Wisconsin Physicians Service, stocks are valued at those market values prescribed by the National Association of Insurance Commissioners, which were, in total, more than book value by $458,003.10. For all other securities of Wisconsin Physicians, the amortized cost is used. The securities owned by the Charitable, Educational, and Scientific Foundation are shown at book value, which was less than market value on December 31, 1968 by $103,021.33.

2. Fixed assets shown above at book value include those of the Charitable, Educational and Scientific Foundation, some of which are shown at appraisal values.

3. Wisconsin Physicians Service participates in a national program covering Federal employees. Final operating results of the entire program for each contract period are reflected in pro rata allocations to each plan. Information relating to the years 1967 and 1968 have not yet become final. Adverse results in total operations of the program could occasion an additional liability when this information is known.

4. Certain payables and receivables between the State Medical Society of Wisconsin and its related organizations are eliminated from assets and liabilities above. These are:

Current Accounts	$ 40,181.12
Mortgage Loans	531,980.36
Paid In Capital and Surplus of WPS Charge Card Corporation	172,678.55
Prepaid Rent	31,535.69
Uncalled Subscriptions For Capital Stock	300,000.00
Total	$1,076,375.72

5. The term, "Restricted Principal of Funds", in this Balance Sheet refers to the Net Worth of those organizations whose funds may be used solely for specifically designated purposes. There is no equity of the State Medical Society of Wisconsin in any of these funds. They are:

Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin
Student Loan Fund of the State Medical Society of Wisconsin
Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin

RECONCILIATION OF NET WORTH

Year Ended December 31, 1968

	State Medical Society of Wisconsin	SMS Realty Corporation	Restricted Fund	Total
Balance January 1, 1968	$109,169.68	$309,302.94	$756,571.08	$1,175,043.70
Increases		36,245.36	138,785.55	175,030.91
Total	$109,169.68	$345,548.30	$895,356.63	$1,350,074.61
Decreases	46,429.32			46,429.32
Balance—December 31, 1968	$ 62,740.36	$345,548.30	$895,356.63	$1,303,645.29

President Callan Makes Committee Appointments

Doctor Robert E. Callan, the incoming president of the State Medical Society of Wisconsin, appointed 26 state physicians to six society committees as one of his first acts in office.

Those appointed are as follows:

Committee on Cancer: Drs. J. R. Hoon of Sheboygan (reappointment); G. Daniel Miller of Oconomowoc (reappointment); F. L. Schaefer of Menasha (reappointment); Dr. C. M. Scott of Superior; and Dr. G. A. Smiley of Delavan, chairman (reappointment).

Committee on Grievances: Drs. M. F. Huth of Baraboo (reappointment); S. L. Chase of Madison; and Elwood Mason of Milwaukee, chairman (reappointment); D. R. Griffith, Eau Claire (reappointment).

Commission on Public Policy: Drs. J. M. Lubitz of Brookfield (reappointment); N. G. Bauch of Milwaukee (reappointment); Thor M. Thorgersen of Waukesha; Roger Laubenheimer of Milwaukee; Rex E. Graber of Chippewa Falls; John R. McKenzie, Jr. of Oshkosh; and William T. Russell of Sun Prairie, chairman (reappointment).

Commission on Health Information: Drs. W. E. Myers of Fond du Lac (reappointment); George W. Dean of Milwaukee (reappointment); R. B. Bourne of Milwaukee (reappointment); and Joseph Devitt of Milwaukee, chairman (reappointment).

Commission on Hospital Relations and Medical Education: Drs. Paul Dietz of La Crosse (reappointment); Donald Koepke of Milwaukee (reappointment); W. R. Manz of Eau Claire; George B. Murphy, Jr. of La Crosse, chairman (reappointment).

Commission on Scientific Medicine: Drs. Edwin C. Albright of Madison; Richard Wasserburger of Madison.

THE COUNCIL AWARD—The highest honor in the power of the State Medical Society to bestow upon one of its members is the Council Award. This year at the annual meeting in Milwaukee May 12–15 it was presented to Dr. H. Kent Tenney (right) of Madison—a descendant of a pioneer Wisconsin medical family, grandson of a physician, and father of a physician—by Dr. E. J. Nordby of Madison, chairman of the Council. Doctor Tenney was cited as a "judicious leader, wise counselor, worthy teacher, stimulating innovator, widely-read author, and imaginative communicator . . . an extraordinary example in the tradition of the Art of the Healer." His specialty of pediatrics has led to several related and distinguished careers. His voice through the "March of Medicine" radio series and his written word in the book "Let's Talk About Your Baby," are perhaps the most popularly known.

Dr. McRoberts . . .

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Dr. McRoberts graduated from McGill University medical school, Montreal, in 1929. He completed a fellowship in surgery at the Mayo Clinic in 1934. He is associated with the Sheboygan Clinic.

In addition to other offices, Dr. McRoberts was a member of the State Board of Medical Examiners from 1951–1959 and served as its president in 1956.

The House of Delegates reelected Dr. G. A. Behnke, Kaukauna, as Speaker, and Dr. T. J. Nereim, Madison, as Vice-speaker.

Drs. W. B. Hildebrand, Menasha, and R. E. Galasinski, Milwaukee, were reelected to two-year terms as delegates to the American Medical Association.

Since Wisconsin is now entitled to five AMA delegates by virtue of an increasing number of members, the House elected Dr. C. J. Picard, Superior, for a 1969–1970 term. Elected as alternate delegates were Drs. G. E. Collentine, Milwaukee; D. J. Carlson, Milwaukee, and H. J. Kief, Fond du Lac. Dr. W. T. Russell, Sun Prairie, will succeed Dr. N. A. Hill as an alternate delegate beginning in 1970.

Dr. James . . .

continued from page 37

He called for careful, unbiased analysis of each case. If this is done, he said, "I am sure that expenses can be significantly reduced."

Dr. James pointed out that analysis of Title 19 expenditures in Wisconsin has revealed that "physicians' fees account for only about 7.8% of the total $115,000,000 spent for such aid."

He said that "freezing physicians' fees will accomplish little toward solving the state's financial dilemma."

DIGNITARIES GET TOGETHER at 1969 annual meeting of the State Medical Society: (left to right) Dr. George Lull, executive vice-president of Chicago Medical Society; Dr. Philip G. Thomsen, president of Illinois State Medical Society; Dr. W. D. James, outgoing president of the State Medical Society of Wisconsin; and Dr. R. E. Callan, incoming president of the SMS of Wisconsin.

Elect 8 Councilors; 7 Are New Dr. Norby Reelected Chairman

PRESIDENTIAL CITATION—An award which is given on occasion by the State Medical Society to a nonmedical person whose interest in medicine has been exemplified by certain accomplishments is the Presidential Citation which was presented to Prof. Karl F. Schmidt (left) at the Society's annual meeting May 12–15 in Milwaukee. Making the presentation was Dr. W. D. James, president. Professor Schmidt, an associate director for Radio at the University of Wisconsin, was cited for "his creative role at WHA Radio" . . . and for "his outstanding contributions to the field of Educational Health, particularly as host of a TV series entitled 'Health Fads and Fallacies,' which gained national attention; but more especially for his portrayal of the Medical Reporter in partnership with Dr. H. Kent Tenney on 'The March of Medicine,' popular broadcast series sponsored by the State Medical Society and heard weekly over more than 35 radio stations."

Eight Councilors, seven of whom will be serving for the first time, were elected to the Council (Board of Directors) of the State Medical Society by the House of Delegates. Those elected were:

- Dr. Leonard W. Schrank, Waupun, First District
- Dr. R. S. Galgano, Delavan, Second District
- Dr. Gordon Davenport, Jr., Madison, Third District
- Dr. Walter F. Smejkal, Manitowoc, Fifth District
- Dr. Howard Mauthe, Fond du Lac, Sixth District
- Dr. Thomas J. Doyle, Superior, Eleventh District
- Dr. Thomas Foley, Milwaukee, Twelfth District
- Dr. William J. Houghton, Milwaukee, Twelfth District, (reelected)

Councilors serve three-year terms. Drs. Smejkal and Mauthe were elected to unexpired terms.

At a meeting of the Council following the Annual Meeting, the Council elected officers for the ensuing year. Dr. E. J. Nordby, Madison, will continue to serve as chairman; Dr. J. M. Sullivan, Milwaukee, as vice-chairman; and Dr. F. L. Weston, Madison, treasurer.

AWARDS FOR BEST SCIENTIFIC EXHIBITS

1969 Annual Meeting
State Medical Society
May 12–15, Milwaukee

GUNNAR GUNDERSEN GOLD MEDALLION AWARD

to

Drs. Allen J. Pois, John Morledge, Gordon A. Tuffli, and Peter Rank, and Jackson Clinic and Methodist Hospital, Madison.

Atrial Septal Defect, Diagnosis and Treatment

SPECIAL MERIT AWARDS

to

1. Drs. W. P. Blount, R. H. Cassidy, and R. C. Zuege, and Columbia Hospital, Milwaukee

   Surgical Treatment of Degenerative Hip Disease

2. Drs. Herbert F. Sandmire and Stephen D. Austin, and Beaumont Clinic, Green Bay

   Intrauterine Contraceptive Device

3. Drs. Samuel R. McCreadie, Donald P. Babbitt, Marvin Glicklich, Shimpei Sakaguchi, L. Gilbert Thatcher, and C. Randolph Turner, and Milwaukee Children's Hospital, Milwaukee

   Diagnostic Approach to Abdominal Masses in Children

4. Dr. Ettore Di Micelli and St. Joseph's Hospital, Milwaukee

   Toxicity of Local Anesthetic Agents and Newer Concepts in Management

5. Dr. William F. Schorr and the Marshfield Clinic and Marshfield Clinic Foundation for Medical Research and Education, Marshfield

   Paraben Allergy: A Subtle Cause of Intractable Dermatitis Caused by Dermatologic and Cosmetic Creams and Lotions

6. Drs. Rodney J. Sturm, John V. Berger, Jr. and John W. Doty, and the University of Wisconsin Department of Surgery (Ophthalmology), Madison

   Corneal Disease and Surgery of the Cornea

AN AESCULAPIAN LAMP was presented to Dr. John R. Evrard of Milwaukee at the Council meeting May 11 preceding the annual meeting of the State Medical Society in Milwaukee. Dr. T. A. Leonard of Madison presented the unique lamp to Doctor Evrard in recognition of his service to the State Medical Society as chairman of its Division on Maternal and Child Welfare, as a valuable member of the Division's Maternal Mortality Study Committee, and in his advancement of the practice of medicine. Doctor Evrard resigned this year as chairman of the Division after serving in that capacity since 1964. Doctor Leonard is chairman of the Maternal Mortality Study Committee.

RECIPIENTS OF THE JOHN H. HOUGHTON, MD Medical Student Award were honored at the 1969 annual meeting of the State Medical Society May 12–15 in Milwaukee with presentation of a plaque and $100 cash grant. They are shown above: Bruce Buchanan (right) and Daniel Kane (left). Buchanan is a student at Marquette School of Medicine and Kane attends the University of Wisconsin Medical School. Making the presentation was Dr. W. D. Stovall of Madison, president of the Society's Charitable, Educational and Scientific Foundation which administers the Houghton fund. The late Doctor Houghton established the award in early 1968 to honor students who "through scholastic excellence, extra-curricular achievement, and interest in the activities of medical organization show high promise of becoming a 'complete physician.' "

PHOTOGRAPHY CONTEST WINNERS

1969 Annual Meeting State Medical Society

May 12–15, Milwaukee

BEST IN SHOW

In the Beginning
Dr. Sheldon L. Burchman
Milwaukee

MEDICINE—Color

Zonular Pigmentation—Left Eye
Dr. Rodney J. Sturm
Madison

MEDICINE—B & W

Chimpanzee
Dr. Sheldon L. Burchman
Milwaukee

TRAVEL—Color

1—El Caballero de Quito
Dr. David J. LaFond
Milwaukee

2—Quechuas of Cuzco
Dr. David J. LaFond
Milwaukee

3—A "Ladder" Street in Hong Kong
Dr. Jack L. Teasley
Milwaukee

HM—Dawn on Lake Lucerne
Dr. David L. Morris
West Salem

TRAVEL—B & W

1—Magnificent Wilderness
Dr. Edgar S. Gordon
Madison

2—Valley of the Jungfrau
Dr. Edgar S. Gordon
Madison

PEOPLE—Color

1—Carousel
Dr. John B. Baker
Milwaukee

2—The Gift
Dr. James R. Hoon
Sheboygan

3—"Autumn in Japan" Dancers
Dr. James R. Hoon
Sheboygan

HM—Woman by the Red Door
Dr. Robert A. Fine
Milwaukee

PEOPLE—B & W

1—Highlights
Dr. Edgar S. Gordon
Madison

continued in adjacent column

PHOTOGRAPHY CONTEST WINNERS continued

2—The Finish Line
Dr. Edgar S. Gordon
Madison

3—Parallel Turn
Dr. Paul J. Meis
La Crosse

HM—High Hurdles
Dr. Edgar S. Gordon
Madison

ANIMALS—Color

1—Silvertip
Dr. N. A. Eidsmoe
Rice Lake

2—Pop Porpoises
Dr. Arthur W. Hankwitz
Milwaukee

3—Egret
Dr. N. A. Eidsmoe
Rice Lake

HM—Pink Tongue
Dr. John Erbes
Milwaukee

ANIMALS—B & W

1—Pastorale
Dr. Paul J. Meis
La Crosse

2—Le Cygne
Dr. Edgar S. Gordon
Madison

3—Ducks Unlimited
Dr. Edgar S. Gordon
Madison

PICTORIAL—Color

1—In the Beginning
Dr. Sheldon L. Burchman
Milwaukee

2—USS Hope
Dr. M. W. Asplund
Bloomer

3—Wisconsin Farm
Dr. John Erbes
Milwaukee

HM—Light from Heaven
Dr. Bryant H. Roisum
Madison

PICTORIAL—B & W

1—Pacific Shore
Dr. Edgar S. Gordon
Madison

2—Ski Scene
Dr. Paul J. Meis
La Crosse

3—Duoma in Milano
Dr. Edgar S. Gordon
Madison

HM—Icy Clutch of Winter
Dr. Edgar S. Gordon
Madison

VIETNAM VOLUNTEER PHYSICIANS—Two Wisconsin physicians who volunteered their services for 60-day tours in Vietnam during the fiscal year 1968–1969 were honored by the American Medical Association at the SMS annual meeting. Plaques were presented to Dr. D. J. Martinetti of Hurley (center) and Dr. W. G. Huibregtse of Sheboygan (left) by Dr. R. E. Callan of Milwaukee (right), president of the State Medical Society.

Dr. John Erbes Popular Winner Woman's Auxiliary Art Salon

Rated one of the best presented in its eight-year history, the Medical Art Salon of the Woman's Auxiliary to the State Medical Society was a continuing favorite with exhibit viewers at the Society's 128th Annual Meeting May 12–15 in Milwaukee.

This year's exhibit was arranged by Dr. and Mrs. John H. Esser and Dr. and Mrs. Richard B. Bourne of Milwaukee.

For the second consecutive year, Dr. John Erbes of Milwaukee captured the Popularity Award with his watercolor painting of *Frenchman's Creek*.

Other winners in specific categories are:

WATERCOLOR PAINTING

1. Joan Wells, Milwaukee, **Last Horizon**
2. Dr. Benjamin Louthan, Milwaukee, **Landscape No. 3**
3. Evelyn Rife, Milwaukee, **Tulips**

OIL PAINTING

1. Dr. William Hovis, Milwaukee, **Saturday Night at the Lichtners**
2. Joan Wells, Milwaukee, **Great Things Are Done When Men and Mountains Meet**
3. Mrs. Robert Leitschuh, Racine, **Hills**

SCULPTURE

1. Dr. Werner A. Hauschild, Kenosha, **Hans**
2. Dr. G. L. Bravick, Appleton, **Head of a Young Man**
3. Dr. John Evrard, Milwaukee, **Great Expectations**

INTERSTATE POSTGRADUATE TEACHING AWARD—Dr. Walter P. Blount of Milwaukee (right) received the Interstate Postgraduate Medical Association's "Erwin R. Schmidt Interstate Teaching Award" from Dr. George B. Callahan of Waukegan, Ill., at the State Medical Society's annual meeting in Milwaukee May 12–15. The award is given annually to a Wisconsin physician who has distinguished himself in the area of teaching of medical students and physicians in practice. The award includes a $500 cash grant and a plaque. Doctor Blount is internationally known for innovations in orthopedics, including bone stapling to control growth in children, treatment of fractures in children, and development, with Dr. Albert C. Schmidt of Milwaukee, of the Milwaukee brace for correcting spinal curvature. He retired in 1968 as chairman of orthopaedic surgery at Marquette School of Medicine. Doctor Callahan is an Illinois trustee of Interstate and a former classmate of Doctor Blount.

NEWS HIGHLIGHTS

State Neurologists Organize

On Saturday, May 10, the Wisconsin Neurological Society was formally organized at a meeting at the Ramada Inn in Madison. There are 36 physicians in Wisconsin who are board eligible or certified in Neurology and are practicing clinical neurology. Twenty-six of the members were present.

At the business meeting the officers elected were: president, Dr. Francis M. Forster,* Madison; president-elect, Dr. Frank Kruse,* Marshfield; vice-president, Dr. Philip White, Milwaukee; and secretary-treasurer, Dr. Harold Booker, Madison. Dr. Hans Reese,* emeritus professor of Neurology, University of Wisconsin, was named honorary president.

The Society has as its aims and goals the improvement of neurologic care and the dissemination of neurologic information in the State of Wisconsin, aiding in recruiting neurologists and para-neurological personnel. Functioning of the Society should lead to a better understanding of statewide neurologic problems, Dr. Forster states.

In addition to the organizational and business meetings, a scientific program was held with a broad gamut of neurologic problems including the recent advances in treatment of parkinsonism, in vitro investigation of drug reactions in the neurologic field, the neurologic aspects of mental subnormality, histochemical studies of muscles, studies in the XYY chromosome abnormal males, and review of supratentorial arachnoid cysts in infancy.

The Constitution Committee consists of Dr. Philip White as chairman with Drs. Henry Peters* and Paul Gottschalk.* The Membership Committee, chaired by Dr. Frank Kruse* and consisting of Drs. Raymond Chun, Dr. Clarke Danforth,* Sik Jew,* and Keith Bogart, is to make recommendations regarding the membership for the future.

Dr. Schilling Heads UW Alumni Group

Dr. Robert F. Schilling of Madison was named president-elect of the Wisconsin Medical Alumni Association at the group's annual alumni day May 23.

Dr. Schilling, professor and chairman of medicine at the University of Wisconsin Medical School, is a 1943 graduate of the school.

Dr. Charles Benkendorf* of Green Bay was installed as president of the organization at the annual banquet that evening. A radiologist, he served his residency at Wisconsin from 1955 to 1958.

Two directors were also elected. They are Dr. Robert M. Senty* of Sheboygan and Dr. Loran F. Thurwachter* of Whitefish Bay. Dr. Senty, a 1947 Wisconsin medical graduate, is an internist, and Dr. Thurwachter, class of 1945, is an anesthesiologist. He is the 1945 class representative while Dr. Senty is a preceptor for the school.

Price of Rh Baby Disease Vaccine Cut Second Time

For the second time in less than a year since the disease preventive was first introduced, the price of a vaccine that prevents Rh hemolytic disease of the newborn has been dramatically reduced.

The new price now in effect, $35.10 a dose, represents a reduction of almost 50 percent in the price at which it first became generally available ($64.80). Ortho Diagnostics introduced the vaccine, called RhoGam® Rh_0 (D) Immune Globulin (Human), last June, and reduced the price to $46.60 last October.

PHYSICIAN BRIEFS

Dr. John J. Beck

. . . Sturgeon Bay, has joined his father, Dr. John G. Beck,* in general practice and will be associated with him at the Dorchester–Beck Clinic, Sturgeon Bay. He graduated from Northwestern Medical School in 1965 and interned at St. Luke's Hospital, Fargo, N.D. Doctor Beck served in the United States Navy for two years, and was the flight surgeon and senior medical officer at El Centro (Calif.) Naval Base until his discharge in March 1969.

Dr. Robert D. Heinen*

. . . Oconto, recently was elected by members of the state chapter of the American Academy of General Practice into active membership in the national association.

Dr. Robert J. Banker*

. . . Manitowoc, recently was named president-elect of the Wisconsin Urological Society at its annual meeting.

Dr. George T. Bryan*

. . . Madison, recently was elected to the American College of Physicians. He was one of eight doctors in Wisconsin and of three in Madison to receive this recognition. The distinction was awarded Doctor Bryan for his research in cancer at the University of Wisconsin.

Dr. F. N. Pansch*

. . . and Drs. Robert E. Dedmon* and Gordon H. Hardie,* Neenah, recently were named chairmen of three major clinical departments at Theda Clark Memorial Hospital, Oshkosh. Doctor Pansch is chairman of the clinical department of obstetrics and gynecology; Doctor Hardie, chairman of the department of surgery, and Doctor Dedmon, chairman of the department of medicine.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dr. Charles S. Hintz

. . . an oral surgeon, and Dr. Richard D. Ulmer, an internist, recently joined the medical staff of the Marshfield Clinic. Doctor Hintz graduated from the University of Minnesota Dental School in 1963 and interned at the Veterans Hospital in Minnesota. He had a year's residency in oral surgery and for the last three years has been a resident in oral surgery at the Mayo Clinic, Rochester. Doctor Ulmer graduated from the Stritch Medical School at Loyola University, Chicago, in 1961 and served a rotating internship at the University of Chicago Hospitals and Clinics. He was a resident in cardiology at the University of Chicago Hospitals and Clinics from June 1968 through March 1969 and was a cardiology instructor at the same institutions. He served in the United States Army for two years where he was assistant to the chief of the department of medicine at the Army Hospital in Ft. Campbell, Ky.

Dr. Linwood C. Gardner*

. . . Fond du Lac physician, specializing in eye, ear, nose and throat, who introduced bronchoscopy in the Fond du Lac area in the late 20s, recently retired. Doctor Gardner had practiced in the area for 42 years.

Dr. Walter P. Blount*

. . . Milwaukee, recently was made an honorary member of the Marquette Medical Alumni Association at its annual dinner. Doctor Blount was chairman of the medical school's department of orthopedic surgery from 1956 to 1968. He is a graduate of the Rush Medical School, Chicago, and is a past president of the American Academy of Orthopaedic Surgeons.

Dr. Henry H. Gale*

. . . and Dr. Donald E. Koepke,* Milwaukee, recently discussed heart surgery at a public heart forum at Wisconsin State University–Stevens Point. The forum was sponsored by the Wood–Portage County Unit of the Wisconsin Heart Association. Dr. R. H. Bickford,* Stevens Point, was the moderator.

UW Medical Students Receive Awards

Thirty-five students received awards and grants at the University of Wisconsin Medical School's honors convocation May 22.

In addition, Dr. William S. Middleton,* emeritus dean of the medical school, received the distinguished teaching award as the result of a senior ballot. The award is presented each year by the Wisconsin Medical Alumni Association.

Andrew B. Szumowski of Kenosha, received two of the student awards, the Charles Russell Bardeen and Lewis E. and Edith Phillips presentations. Other awards:

Guro Bjornson Scholarship—David D. Norenberg, Neenah; William J. Bleckwenn, Jr. Award—John E. Woodford, Racine; Borden Award—John V. Temte, Madison; The Drs. Joseph Dean Award—Dorothy J. Ganick, Boston, Mass.;

Evan and Marion Helfaer Awards—Robert M. Bumsted, Janesville; Patrick K. Keane, Appleton; Daniel D. Kane, Jr., West Allis; Daniel N. Wochos, Denmark; Daniel E. Hathaway, Madison; Mrs. Mary Kirk Sawyer, Monroe, La.; Tom D. Ivey, Mineral Point; Leslie A. Leppla, New Berlin; Kenneth W. Feldman, Newton Highlands, Mass.; Robert H. Jacqmin, Green Bay; and G. F. Splittgerber, Oshkosh;

Pfizer Laboratories Medical Scholarship—Stephen W. Rutter, La Crosse; Dorothy and Charles Inbusch Award—Lawrence G. Tomasi, Ferndale, Mich.;

Lewis E. and Edith Phillips Award—Mrs. Mary E. L. Wilson, Kokomo, Ind.; William E. Smith, Beaver Dam; Peter W. Schmitz, Elm Grove; Thomas P. Laughren, Madison; Michael J. Ansfield, Shorewood; Wayne J. Pietz, St. Germain; Thomas J. Pauly, La Crosse;

Radiology Case of the Week Awards—Douglas E. Thomson, Mount Horeb, and Karl T. Wickstrom, Clare, Mich.; Roche Award—Craig G. Stien, Stevens Point.

UW Foundation Awards—Stephen A. Bernsten, Skokie, Ill.; Paul E. Sandstrom, Springfield, Pa.; David L. Davis, Reedsburg; and Stanley B. Chung, Kowloon, Hong Kong;

James M. Price Award in Cancer Research—Samuel M. Cohen, Edgerton; Upjohn Award—Mary B. Metcalf, La Crosse; and Ralph M. Waters Medical Scholarship—William B. McHugh, Pittsburgh, Pa.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MAY 1969

1 Board of Directors, WPS Charge Card Corp.
1 SMS Commission on Medical Care Plans
1 Junior students and faculty, University of Wisconsin Medical School
3 Board of Directors, Wisconsin College Health Association
5 Insurance Advisory Committee, Dane County Medical Society
6 Madison Anesthesiology Society
6 Madison Urological Society
6 Board of Trustees, Delegates and Alternates to SMS, Dane County Medical Society
10 Executive Committee of SMS Council (Milwaukee)
10 Wisconsin College Health Association
11 SMS Council (Milwaukee)
12 SMS Annual Meeting (Milwaukee)
12 Madison Memorial High School Student Tour
12 Utilization Review Plan, Dane County Medical Society
13 SMS Annual Meeting (Milwaukee)
14 SMS Annual Meeting (Milwaukee)
15 SMS Annual Meeting (Milwaukee)
19 Dane County Medical Auxiliary Benefit Sale
21 Individual Physician's Profile
21 Perinatal Unit, Madison Obstetrical Division
22 Planning Conference on Drug Education
26 Committee on Drug Dependency, State Department of Health and Social Services

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Social Security Benefits

Unemployed insured teachers of retirement age may collect social security benefits for the summer months.

HELEN F. CALLON, RN—Upon her retirement March 31 from the Section of Maternal and Child Health of the Division of Health of the State Department of Health and Social Services, Miss Helen Callon was honored by the State Medical Society at a special dinner event March 18 in Society headquarters. Hosting the event were members of the Maternal Mortality Study Committee and the Division on Maternal and Child Welfare with whom Miss Callon had worked so closely over the years. She was presented a plaque and purse of money as "a small token of respect and admiration." Shown with her above are Dr. T. A. Leonard* (left) of Madison, chairman of the Maternal Mortality Study Committee, and Dr. W. D. James* (right) of Oconomowoc, at that time president of the State Medical Society.

SMS Auxiliary Awards Scholarships

The Woman's Auxiliary to the State Medical Society has awarded scholarships to five 1969 high school graduates. The recipients are: Kathleen Ksobiech, Mukwonago; Linda Larson, New Richmond; Sharleen Peterson, Ladysmith; Diane Sugent, Racine; Marla Timm, Two Rivers.

Miss Ksobiech will take her training at Mount Sinai Hospital School of Nursing in Milwaukee; Miss Larson has been accepted at Wisconsin State University at Eau Claire; and Miss Peterson will enroll in Alverno College, Milwaukee, in the fall.

Miss Sugent has chosen medicine as a career and will enter Marquette University in Milwaukee. Miss Timm will also enroll at Marquette in the physical therapy department. Each girl will receive a $200 scholarship.

Funds for the scholarships were raised through Auxiliary dues and donations from county medical auxiliary units.

Members of the selection committee were: Mrs. W. P. Curran, Antigo, chairman; Mrs. James W. Sargent, Milwaukee; Mrs. William Smollen, Racine; and Mrs. T. W. Tormey, Madison. Announcement of the awards was made during the annual meeting of the Auxiliary held in Milwaukee May 12–15.

Neuro-Psychiatrists Elect

At the May 21 meeting of the Milwaukee Neuro-Psychiatric Society, the following officers were elected for the coming year:

President—Dr. Charles W. Landis,* president-elect—Dr. John W. Markson,* secretary—Dr. William H. Studley,* treasurer—Dr. Leo B. Perssion,* and councilors—Drs. Jules D. Levin,* Ervin Teplin, and Preston W. Thomas.*

Dr. W. D. Stovall*

. . . Madison, was featured in a recent issue of the *Wisconsin Medical Alumni Quarterly*. The emeritus professor of hygiene of the University of Wisconsin Medical School, retired in 1961 as director of the State Laboratory of Hygiene. He then became a special assistant to the dean of the medical school.

During his "retirement" he has been traveling extensively throughout the state visiting with judges, nurses, physicians, veterans, welfare officials, and just about anybody to maintain personal communication between the University, the people of Wisconsin, and the medical community. Dr. Stovall is president of the State Medical Society's Charitable, Educational and Scientific Foundation, and the exhibit building at the Museum of Medical Progress in Prairie du Chien is named in his honor—Stovall Hall of Health.

Dr. James C. Fox*

. . . La Crosse, was honored by Pope Paul VI April 27 when he was made a Knight in the Order of the Holy Sepulcher. The award was made at investiture services in Old St. Louis Cathedral in La Crosse. Dr. Fox received the honor for his services to the community and to the Roman Catholic church. He was formerly chairman of the State Medical Society's Council.

Dr. Gamber F. Tegtmeyer*

. . . has resigned from the Marquette medical school board. Also resigning was John W. Cowee, executive vice-president of the medical school board and provost of Marquette University. Cowee's resignation is expected to strengthen the medical school's bid for state funds to help its annual operating deficit of about $1.3 million, since his association with the University was the last remaining link between the University and the medical school. The association had to be broken in order to conform to the recently enacted legislation to provide state funds to help operate the medical school. Dr. Tegtmeyer is a retired medical director of Northwestern Mutual Life Insurance Co.

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.

Dr. Ernest S. Olson*

. . . Racine, recently retired from his twin post of Director of Clinical Laboratory Services and Chief Pathologist at St. Luke's Hospital. He will remain on the laboratory staff as pathologist emeritus. Dr. Claude E. Oberdorfer,* associate pathologist at St. Luke's Hospital since 1959, was named to succeed Doctor Olson.

Dr. Mortimer M. Bortin*

. . . laboratory director of Mount Sinai Hospital in Milwaukee, is one of the 12 United States scientists invited to attend an international workshop in Paris on human bone marrow transplantation. Doctor Bortin recently received a $28,100 grant from the Patrick and Anna Cudahy Fund to continue his research.

Dr. A. C. Bachus*

. . . and Drs. Otto A. Dittmer,* J. M. Johnson,* Russell S. Pelton,* Stewart Lofdahl* and William H. Schuler,* Ripon, recently combined forces to provide emergency medical service on a 24-hour basis. A separate telephone number has been set up and attached to a mechanical answering device, which gives the name and telephone number of the doctor on call for that day. All patients cared for under this program are referred to the patient's regular doctor for follow-up care, unless the patient prefers to continue with the doctor on call. The doctor on call makes every effort necessary to contact the patient's doctor in case of emergency surgery.

Dr. William B. Hobbins*

. . . Madison, recently attended a conference in Washington, D.C., which was sponsored by the American Cancer Society, the U.S. Public Health Service, and the Mammography Society.

Dr. Andrew M. Lucas*

. . . Wisconsin Rapids, and Dr. Russell F. Lewis,* Marshfield, recently participated on a panel of a family planning symposium which was held in Wisconsin Rapids. The Wood County Council of Social Agencies sponsored the program.

Dr. Wm. Bennett a Medical Missionary to Guatemala

A month-long trip providing medical care to Indians in the nearly inaccessible mountain area of Guatemala was recently completed by Dr. William H. Bennett,* a Racine ophthalmologist.

He was accompanied on the working vacation by his wife, daughter, and son-in-law, Dr. Clarence Sampson, also an ophthalmologist practicing in New Orleans, La.

During the stay, Doctor Bennett performed 91 operations and treated 1,500 cases. The volunteer work was performed in behalf of the Maryknoll Sisters, an American Catholic Missionary group with main headquarters in Maryknoll, N.Y.

This was the second volunteer trip made by Doctor Bennett in the past two years. He previously had "vacationed" in Taiwan with his wife and a Milwaukee ophthalmologist, Dr. Donald Hughson,* and his wife.

Dr. William Bennett
(Photo courtesy RACINE JOURNAL–TIMES)

Wisconsin Surgeons to Meet in Austria

The Wisconsin Surgical Society will be meeting this year in Innsbruck, Austria, Sept. 18–24.

The Society's secretary, Dr. Wilson Weisel,* has announced that space on flights is available at group rates for members of the State Medical Society wishing to go to Austria–Munich and return to Milwaukee from Munich.

Flights will leave Milwaukee Sept. 16 and return from Munich to Milwaukee on Oct. 7.

For those interested, immediate contact should be made to Mrs. Alice Smith of Thomas Cook and Son, 320 East Wisconsin Ave., Milwaukee, Wis. 53202, 414/273–1300.

Medical Clinic Opens, Osseo

A new medical clinic located near the Osseo Area Hospital opened in mid-May. Drs. R. N. Leasum,* B. G. Garber,* and R. D. Garber* are the occupants.

Wisconsin Alumnus to Head Chest MDs

Dr. Alfred Soffer, editor-in-chief of *Diseases of the Chest* and professor of Medicine, Chicago Medical School–University of Health Sciences, will assume the position of executive director of the American College of Chest Physicians on July 15. Dr. Soffer will succeed Mr. Murray Kornfeld, executive director since the founding of the College in 1935.

Born in South Bend, Ind., Dr. Soffer received his high school education in Beloit, Wis. He obtained his MD from the University of Wisconsin and took residency training in internal medicine at St. Louis and Rochester, N.Y.

Dr. Soffer served for six years as a senior editor of the *JAMA*.

Surgical Society Elects

At its annual meeting May 15 in Milwaukee the Wisconsin Surgical Society elected the following officers: president, Dr. Kenneth L. Carter,* Beloit; president-elect, Dr. C. Sherrill Rife,* Milwaukee; secretary, Dr. Wilson Weisel,* Milwaukee; and recorder, Dr. Wayne Boulanger,* Milwaukee.

New Council members are: Drs. Robert O. Johnson,* Madison, and Donald Koepke,* Milwaukee.

New Diagnostic for Sickle Cells Called Superior to Metabisulfite

A recently-developed way to diagnose sickle cell hemoglobin is more accurate, faster and simpler to perform than previous chemical tests, according to a pathologist's report recently published in *The Journal of the Indiana State Medical Association.*

Associate Professor of Pathology at Chicago Medical School, Dr. Wei-Ping Loh reported that the new, prepackaged test is "more sensitive and reliable than the standard metabisulfite test, which has a number of inherent inaccuracies."

Doctor Loh is Chief Pathologist of Methodist Hospital in Gary, Indiana, where he evaluated the new diagnostic by using it routinely with 600 Negro patients and comparing the results with those obtained by the metabisulfite method. Positive and negative controls were employed.

"No false results were seen among the 600 patients tested," reported the physician, who found among them an Hb-S incidence of 8.5 percent.

The new diagnostic method is Sickledex® Tube Test For Hemoglobin S. Introduced recently by Ortho Diagnostics, it takes three to five minutes, and requires no special training or equipment.

Doctor Loh reported that his interest in sickle cell disease was stimulated by its possible implication in unexplained surgical deaths. "It became clear that detection of abnormal hemoglobin before major surgery would help in the selection of anesthesia and prevention of hypoxia . . . No unexpected surgical death occurred during 9½ months of investigation when tests for detection of Hb-S were performed routinely on Negro patients before surgery."

The differential solubility test "can be easily performed in a doctor's office and can be used for mass testing because only minimum equipment is needed," the pathologist stated.

Dr. Pallin Chairman Anesthesiology Section

At the May 15 meeting of the Section on Anesthesiology of the State Medical Society, Dr. J. N. Pallin* of Fond du Lac was elected chairman and Dr. Ruth A. Stoerker* of Madison, secretary.

Dr. Pallin is president-elect of the Wisconsin Society of Anesthesiologists and Dr. Stoerker is secretary of the same group.

The delegate elected is Dr. Jergen L. Barber* of Waukesha, and alternate delegate, Dr. G. Daniel Miller* of Oconomowoc. These delegates succeed Drs. Sheldon Burchman* of Milwaukee and John Temple* of Wauwatosa.

Milwaukee Academy of Medicine

Dr. Jesse E. Edwards of St. Paul, Minn., will speak on congenital heart anomalies in the adult at the Oct. 21 meeting of the Milwaukee Academy of Medicine at the University Club of Milwaukee.

NARCOTICS REGISTRATION DEADLINE IS JULY 1

All physicians registered under the Harrison Narcotic Act or the Marihuana Tax Act must re-register and pay a tax of $1.00 by *July 1*. Failure to comply with the law may result in severe penalties. If you have not received forms for separate registration and inventory of narcotics and marihuana, contact the Office of the Director of Internal Revenue, Federal Building, Milwaukee 53201. Physicians with more than one office must register for each since each office is required to have a separate registration number.

Dr. Miguel A. Sanguino

. . . recently became associated with the medical staff of The Monroe Clinic in the department of Neurology. He is a native of Cucuta, Colombia. Doctor Sanguino graduated from the National University of Colombia in Bogota and served his internships at San Juan Hospital, Cucuta and St. Joseph Hospital in Providence, R. I. His residency training was taken at D. C. General Hospital, Washington, D.C., the University of Wisconsin and the Veterans Administration Hospital in Madison. He is a member of the American Academy of Neurology and the American Association for the Advancement of Science.

Dr. Ralph L. Suechting*

. . . Oshkosh, recently was elected president of the medical staff at Theda Clark Memorial Hospital, Oshkosh. Dr. Donald J. Ryan* was elected vice-president and Dr. Paul E. Wainscott* was elected secretary.

Dr. Roy Hertz

. . . a UW Medical School alumnus, class of '39, was recently honored by the International College of Surgeons. The Ann Langer Cancer Research Foundation Award for 1969 was given to Doctor Hertz at a reception inaugurating the first International Symposium on Gynecological Surgery sponsored by the ICS. The award recognized him for his meritorious investigation into cancer surgery and particularly for his effective chemotherapy of trophoblastic tumors in women. The award included a plaque listing his contributions to cancer research along with a $1000 honorarium. Doctor Hertz is Chief, Reproduction Research Branch, National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, Md.

Dr. Jerome W. Fons*

. . . Cudahy obstetrician and gynecologist, recently was awarded the Cudahy Jaycees annual Distinguished Service Award. Active in community affairs, Doctor Fons has written several medical articles including an article published in "History of Medicine."

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

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desipramine hydrochloride

In depression...
when words are not enoug

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

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Ardsley, New York 10502

The go-ahead-and-enjoy-your-vacation summer cold and allergy pill.

Novahistine LP lets you provide effective relief of summer cold and allergy symptoms, lets your patients go ahead and enjoy their vacations.
These continuous-release, decongestant tablets contain a vasoconstrictor-antihistamine formulation that goes to work promptly and lasts for hours. Even the nasal congestion resulting from repeated allergic episodes can usually be relieved by Novahistine LP.

And, convenient twice-a-day dosage lets most patients enjoy relief all day and all night. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW

Dr. Meb Qureshi

. . . has joined the staff of The Monroe Clinic in the department of Internal Medicine. He is a native of Ahmedabad, India, and earned his medical degree at the Royal College of Surgeons in Dublin, Ireland. Doctor Qureshi served his internship at St. Luke's Hospital in Newburgh, New York, and his residency was taken at St. Lawrence Hospital, Lansing, Mich. He was on the medical staff at Emily P. Bissell Hospital in Washington, D.C. prior to joining the staff at The Monroe Clinic. He is a member of the American Thoracic Society and the American Professional Practice Association.

Dr. Henry E. DeGroot*

. . . Racine, recently was elected a fellow of the American College of Physicians at a meeting held in Chicago. Two other Racine physicians were honored by the organization previously, Dr. C. R. Newman* and the late Dr. Kenneth Kehl.

Dr. Irwin E. Gaynon*

. . . presented a scientific exhibit May 5–7 at the annual session of the Wisconsin State Dental Society in Milwaukee. The exhibit, titled "Early Nasal Injury—A Factor in Nasal, Septal, Dental and Facial Deformities," included a number of transparencies from the library of the American Rhinologic Society. Doctor Gaynon is Chief of the Department of Otorhinolaryngology, Saint Michael Hospital, Milwaukee.

Dr. Max M. Smith*

. . . Madison, recently was elected president of the medical staff of St. Mary's Hospital. Others elected to the executive committee are Drs. W. T. Russell,* vice-chief of staff; C. H. Geppert,* secretary-treasurer; G. N. Kerrihard,* Dane County Medical Society representative; J. C. McAleavy,* chief of anesthesiology; D. M. Connors, pathology; P. O. Simenstad,* internal medicine; E. L. Roley,* obstetrics and gynecology; C. E. Hopkins,* pediatrics; J. N. Moore,* general practice; R. J. Botham,* surgery, and O. A. Stiennon,* radiology.

Urgent Need for Volunteers to Vietnam

The U. S. Agency for International Development has requested that the AMA continue its administration of the "Volunteer Physicians for Viet Nam" program for an additional two years.

To maintain 32 physicians in Vietnam until June 1971 will require an additional 400 volunteers. The greatest need is for general practitioners, general surgeons, internists, orthopedic surgeons, pediatricians, and preventive medicine specialists.

Dr. John Hannah, newly appointed administrator for USAID, stated recently at a reception for the 600th departing volunteer, "these physicians volunteer to serve in Vietnam not because it is where the action is, but because it is where the need is."

Interested physicians should contact the Director, Volunteer Physicians for Viet Nam Program, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

INTERNIST MEETING SITE CHANGED TO KAEHLERS

The annual fall meeting of the Wisconsin Society of Internal Medicine has been changed from Deer Park Lodge to Kaehlers Resort, Lake Delton (formerly Uphoff's). Dates: Sept. 11–13.

The Program Committee is working diligently on the program which will again be presented in cooperation with the American College of Physicians.

The Friday program will be a panel on "Diseases of the Liver." It will feature Dr. William P. Baldus of the Mayo Clinic, Dr. James D. Carey, Jr. of the University of Minnesota Medical School, Dr. Henry C. Pitot* of the University of Wisconsin Medical School, Dr. Leslie Schoenfield of the Mayo Clinic, and Dr. Mitchell A. Spellberg of Chicago.

The Middleton Lectureship will be given by Dr. H. Marvin Pollard, president of the American College of Physicians.

The Friday afternoon session will be on "Computers in Medicine." Saturday morning the schedule will be on "Infectious Diseases." Featured will be Dr. Harry Harding of Evanston, Ill.; Dr. Burton A. Waisbren,* Milwaukee; Dr. Michael W. Rytel, Milwaukee; and Dr. Allen C. Kind,* Madison.

Jackson Clinic Hosts 84 MDs at PG Course

Eighty-four physicians registered for the Spring Postgraduate Meeting of the Jackson Clinic and Foundation, held May 1 at the Park Motor Inn, Madison.

Dr. Joseph M. Kiely of the Mayo Clinic spoke on "Current Use of Computers in Clinical Medicine." He also participated in a panel discussion on "Therapy of Inoperable, Recurrent, or Metastatic Malignancy: The Most Common Neoplasms." Other panelists were: Drs. Klaus D. Backwinkel, Barbara A. Brew, William B. Parsons, Jr., and Peter Rank.

Following a social hour and dinner for the physicians and their wives, William M. Dawson, theater director of the University of Wisconsin, spoke on "Cultural Explosion: Fact or Fiction?"

SANDOZ PSYCHOTHERAPY FILM

The Scream Inside—Emergence Through Group Therapy

Now available for qualified professional audiences

The film presents a wide range of psychotherapeutic group processes and dynamics on many levels, with actual therapy sessions photographed or videotaped. Patient conversation is free of restrictions on subject matter or vocabulary.

The purpose of this film is to communicate concepts basic to an understanding of therapeutic group functions and objectives.

It may be obtained for showing by addressing a request to Medical Film Department, Sandoz Pharmaceuticals, Route #10, Hanover, N.J.

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Dr. Francis M. Forster*

. . . Madison, chairman of the department of neurology at the University of Wisconsin Medical School, recently was guest speaker at the spring symposium on neurological disorders held at the Marshfield Clinic. The symposium was sponsored by the Marshfield Clinic Foundation. Members of the Marshfield Clinic staff who participated on the panel were: Drs. David J. Ottensmeyer,* Herbert K. Fischer,* Paul Gottschalk,* and Mariella Fischer–Williams. A roundtable discussion which included all of the speakers and Dr. Ben R. Lawton,* president of the Clinic, concluded the program.

Dr. Joseph P. Bender*

. . . and Dr. David B. Pierpont,* Chetek, have been elected to active membership in the American Academy of General Practice.

Dr. George A. Hellmuth*

. . . director of the Classification Unit of the Curative Workshop of Milwaukee, attended an invitational National Workshop on Exercise, in the Prevention, in the Evaluation, and in the Treatment of Heart Disease. The meeting was held May 6–8 in Myrtle Beach, S. C.

Doctor Hellmuth also wrote an editorial, "Whither Work Evaluation Units," which was published in the March 1969 issue of *Circulation.*

Dr. J. D. Farrington*

. . . Minocqua, an orthopedic surgeon, stressed the urgent need for adequate emergency care and transportation of critically injured persons when he spoke at the annual conference of the Wisconsin Council of Safety May 8 in Milwaukee.

"We need an informed public and medical profession," Dr. Farrington said. "There is a great deal of information pertaining to the care and needs of the critically injured and ill. What we have to do is to disseminate it."

The two-day conference attracted representatives of business, industry, schools, hospitals, and churches as well as state and local government agencies.

Surgeons Form State Chapter to ACS

A Wisconsin Chapter of the American College of Surgeons was established May 15 in Milwaukee.

Dr. Edwin H. Ellison* of Milwaukee was named president; Dr. Herman Wirka,* Madison, vice-president; Dr. Victor S. Falk,* Edgerton, president-elect; and Dr. Kendall E. Sauter,* Milwaukee, secretary-treasurer.

Councilors elected are: Drs. George Nadeau, Jr.,* Green Bay; George Pratt,* Rhinelander; Frank M. Hilpert,* Racine; and Adolph Gundersen,* La Crosse.

The organizational meeting was called by Drs. Peter A. Midelfart,* Eau Claire, and William H. Frackleton,* Milwaukee, ACS governors for Wisconsin.

The Wisconsin Chapter of ACS will provide a forum for the more than 400 Fellows in the state, and give them an opportunity to participate in promoting the ideals, objectives, and activities of the College at the local level.

The Governors state that it will not conflict with any existing surgical organizations and will be a voice to speak for all surgery, not general surgery alone.

Press Panel at Waukesha

The editors of the four newspapers in the Waukesha county area participated in a PRESS PANEL discussion June 4 at the regular meeting of the Waukesha County Medical Society.

Members of the panel were: Richard S. Leonard, editor-in-chief of the *Milwaukee Journal;* Gib Koenig, editor of the *Waukesha Freeman;* Guy Fuller, editor of the *Menomonee Falls News;* and Bart Brown, editor of the *Oconomowoc Enterprise.* Moderator of the panel was Gale Brennan, executive secretary of the Waukesha County Medical Society.

Questions of medical news coverage, what does and what does not constitute medical news, ethical restrictions on physicians concerning patient–doctor relationships, along with the questions of medical news sources and accuracy in reporting were discussed.

A major objective of the panel discussion was to establish better rapport and mutual understanding among members of the medical profession and responsible representatives in the field of practicing journalists.

Monroe Physicians Have Unique Association

According to a recent report from Monroe, the Medical Center of Monroe is unique in that it is the only clinical group in the United States that can make the statement that all the full-time partners are members of Alpha Omega Society.

This honorary medical fraternity represents the top 8 percent of all graduating classes of medical schools throughout the country.

And each of the five physicians in the Medical Center received their honors from different universities.

Dr. C. O. Miller* received his honor from Marquette School of Medicine, Milwaukee; Dr. John Irvin,* University of Wisconsin–Madison; Dr. Donald Springer,* Loyola University, Chicago; Dr. C. E. Baumle, University of Chicago; and Dr. J. F. Murray,* University of Virginia, Charlottesville.

DR. NAJAT DISCUSSES CORN PICKER INJURIES

Dr. Hushang Najat* of Monroe addressed members of the Green County Medical Society and staff of St. Clare Hospital on corn picker injuries to the hand April 21 at the hospital.

During the business meeting of the Society, Dr. E. E. Eckstam* discussed training of ambulance drivers and Dr. F. C. Stiles* reported on preschool examinations. Dr. William E. Hein,* vice-president of the Society, reported on progress of regional planning committees. There were 36 members present for the Society meeting.

CONTRIBUTIONS—CES FOUNDATION

April 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for April 1969:

Nonrestricted

State Medical Society	Voluntary contributions of 298 MDs
State Medical Society	Memorial: Joseph E. Halloin, MD
State Medical Society	Memorial: B. H. Schlomovitz, MD
State Medical Society	Memorial: W. L. Herner, MD
State Medical Society	Memorial: Wm. H. Dohearty, MD
State Medical Society	Memorial: David A. Maas, MD
State Medical Society	Memorial: George H. Scanlon, MD (Iowa Blue Shield Board Chairman)
Mrs. Paul Cunningham	Memorial: Kent Cunningham
Polk County Medical Society	Memorial: David A. Maas, MD
F. L. Whitlark, MD	Memorial: David A. Maas, MD
H. A. Dasler, MD	Memorial: David A. Maas, MD
W. R. Byrne, MD	Memorial: David A. Maas, MD
Daniel Schroeder, MD	Memorial: David A. Maas, MD
Ilma & Herman Toser	Memorial: Mrs. Anna Dumbleton
Dr. and Mrs. C. F. Broderick	Memorial: Mrs. Lawrence Henrickson
Mr. and Mrs. E. R. Thayer	Memorial: George La Bissoniere
David N. Goldstein, MD	Memorial: Mrs. Rose Letven

Museum of Medical Progress

State Medical Society	Voluntary contributions of 7 MDs

Student Loans

State Medical Society	Voluntary contributions of 65 MDs

Charitable

State Medical Society	Voluntary contributions of 36 MDs

Scientific Teaching

State Medical Society	Voluntary contributions of 10 MDs
Merck & Co. Inc.	Speakers Service

Donations Other Than CESF Projects

State Medical Society	Voluntary contributions of 33 MDs

G. W. Hilliard, Jr., MD, Fellowship Fund

Robert B. Murphy	Memorial: G. W. Hilliard, Jr., MD
H. O. Brower	Memorial: G. W. Hilliard, Jr., MD
E. J. Nordby, MD	Memorial: G. W. Hilliard, Jr., MD
Robert E. Callan, MD	Memorial: G. W. Hilliard, Jr., MD
C. H. Crownhart	Memorial: G. W. Hilliard, Jr., MD
State Medical Society	Memorial: G. W. Hilliard, Jr., MD
Peter L. Eichman, MD	Memorial: G. W. Hilliard, Jr., MD

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Voluntary contribution

Danforth Medical Student Loan Fund

Mrs. Quincy H. Danforth	Voluntary contribution

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorial: Mrs. Russell Lewis, Sr.
C. H. Crownhart	Memorial: Mrs. Don Anderson
C. H. Crownhart	Memorial: George La Bissoniere
C. H. Crownhart	Memorial: Kent Cunningham

History of Nursing in Wisconsin

Racine District of Wisconsin Nurses Ass'n	Voluntary contribution
Sheboygan County District Nurses Ass'n	Voluntary contribution
Waukesha County District Nurses Ass'n	Voluntary contribution
Mrs. Walter J. Kowaleski	Voluntary contribution

Dr. B. F. Sowers

. . . has joined the VA medical staff as acting chief of the Surgical Service at Tomah. A graduate of the University of Michigan Medical School, Ann Arbor, Doctor Sowers served as chief of the Admissions and Outpatient Services at the VA Research Hospital, Chicago, from 1965 to 1968.

Dr. K. C. Bill*

. . . and Drs. Henry R. Mol* and Joseph B. Schrock,* Elkhorn, were the panelists at a recent public heart forum in Elkhorn. The topic of the discussion was "Risks to Your Heart and What You Can Do About Them."

Dr. William Reed*

. . . Watertown, is serving as chairman of the professional education committee of the Jefferson County Unit of the American Cancer Society.

Dr. James C. Tankersley*

. . . La Crosse, recently was elected to Fellowship in the American Academy of Pediatrics at its recent meeting in Boston.

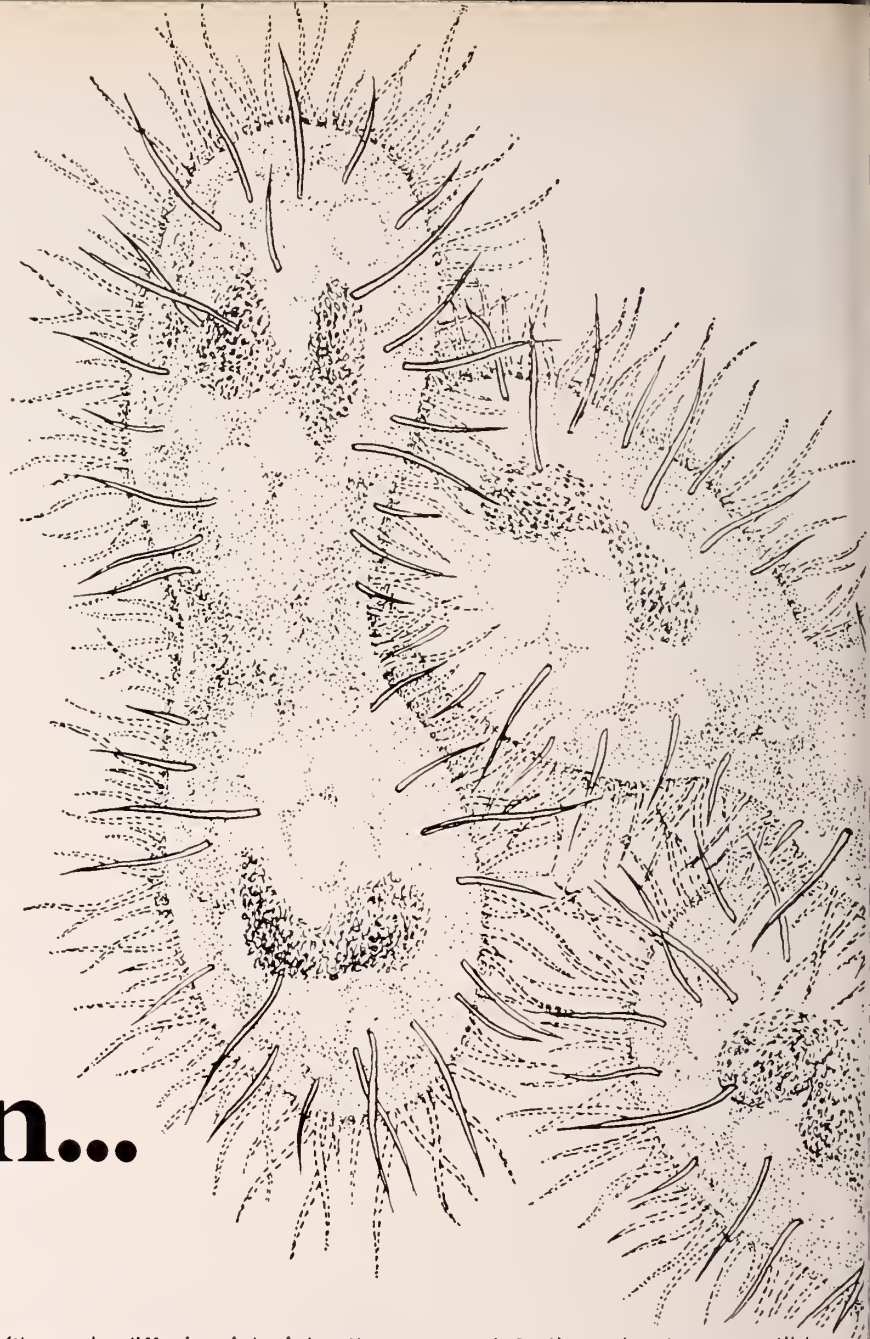
Dr. Gloria E. Sarto*

. . . Madison, Department of Obstetrics and Gynecology, University of Wisconsin Medical School, presented a paper on "The Amniotic Cell Culture for Intra-uterine Diagnosis," at the meeting of the Society of Gynecologic Investigation held in Denver in March. Other physicians who attended the meeting were Drs. Luis Curet* and William Kiekhofer* from the University of Wisconsin Medical School.

Dr. J. L. Weygandt*

. . . Sheboygan Falls, attended the International Association for Accident and Traffic Medicine in early June in New York. While there he also transacted business as secretary of the American Association for Automotive Medicine which is having a meeting Oct. 16–17 at the Mayo Auditorium in Minneapolis.

While in New York he was privileged to have lunch in the Delegates Dining Room at the United Nations.



A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

OBITUARIES

Dr. Allen G. Johnson, 56, Rhinelander, died Apr. 3, 1969, in Ft. Lauderdale, Fla.

Born on July 2, 1912, in Brainerd, Minn., Doctor Johnson graduated from the University of Minnesota Medical School in 1939 and interned at St. Mary's Hospital, Duluth, Minn. He served in the United States Army Air Force during World War II. After completing service, Doctor Johnson practiced in Rice Lake for 11 years before associating with the Schiek Clinic, Rhinelander, in 1957.

He was a member of the Oneida–Vilas County Medical Society, State Medical Society of Wisconsin, and American Academy of General Practice.

Surviving are his widow, Katherine; and two daughters, Mrs. Charles (Katherine) Lovas, Youngstown, O., and Barbara M., a student at the University of Wisconsin, Madison.

Dr. George W. Hilliard, 54, prominent Milwaukee physician and surgeon, died Apr. 8, 1969, in Milwaukee.

Born Feb. 7, 1915, in Toccopola, Miss., Doctor Hilliard graduated from Meharry Medical School, Nashville, Tenn., in 1942. He served his internship and took postgraduate training at Hubbard Hospital, Nashville.

He was a delegate and served on the Commission on Hospital Relations and Medical Education of the State Medical Society of Wisconsin. Doctor Hilliard was a member and treasurer of The Medical Society of Milwaukee County, a fellow of the American College of Surgeons and the International College of Surgeons, member of the American Federation for Clinical Research, and was certified by the American Board of Surgery. He was a diplomate of the Pan-American Medical Association.

He also was a member of the State Medical Society of Wisconsin, American Medical Association, and the National Medical Association.

Surviving are his widow, Joy; three sons, George W. III, Lawrence, and John of Milwaukee; three daughters, Mrs. Dana J. Warren and Emlee J., Milwaukee, and Hattie J. of New York; also his mother, Mrs. George W. Hilliard, Sr., Beloit.

Dr. Robert F. Mack, 34, Marshfield, died Apr. 15, 1969, in Marshfield.

Born on Nov. 29, 1934 in Waterville, Minn., Doctor Mack graduated from the University of Minnesota Medical School in 1963, and took his internship and did postgraduate work at St. Mary's Hospital, Duluth, Minn. He became associated with the Marshfield Clinic in the summer of 1968 after completing his postgraduate work.

He was a member of the Wood County Medical Society, State Medical Society of Wisconsin, and American Medical Association. He also was a member of the Minnesota Academy of General Practice.

Surviving are his widow, Marion, and three children.

Dr. Frederick R. Pollock, 63, chief of staff at the Tomah Veterans Administration Hospital, died Apr. 22, 1969, in Tomah.

He graduated from Northwestern University Medical School in 1930 and was on the staff of Jackson State Hospital, Jackson, Ill., for five years. He was in general practice in Chicago from 1936 to 1943 when he entered the United States Army Medical Corps and served in the European Theatre during World War II. Doctor Pollock became associated with the medical staff at the Tomah Veterans Administration Hospital in 1947 and became its chief of staff in 1964.

Surviving is his widow, Ruth.

Dr. George W. Beebe, 87, retired Eau Claire physician, died Apr. 24, 1969, in Eau Claire.

Born on Feb. 22, 1882, Doctor Beebe graduated from Albany Medical College, New York, in 1907 and practiced medicine at St. Johnsville, N.Y., when he entered World War I in 1917. In 1919 he moved to Eau Claire and was engaged in private practice until 1938 when he became the medical director at Mt. Washington Sanatorium. In 1949 he returned to private practice until 1960. Doctor Beebe was an active member with the Wisconsin Tuberculosis Association.

He was a member and past president of the Eau Claire–Dunn–Pepin County Medical Society, a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving is a son, Thomas, of Eau Claire.

Dr. Frederick W. Hammond, 96, Manitowoc County's oldest physician and surgeon, died May 8, 1969, in Manitowoc.

Born Mar. 17, 1873, at Cato in Manitowoc County, Doctor Hammond graduated from Milwaukee Medical College in 1898. He took postgraduate work in surgery at the Chicago Postgraduate School of Medicine, clinics in New York and Johns Hopkins University, and also attended surgical clinics in Europe.

In 1968, Doctor Hammond was honored at a dinner sponsored by the Manitowoc County Medical Society for his 70 years of practice of medicine in the County. He became a life member of the State Medical Society of Wisconsin in 1949, and in 1951 he joined the State Medical Society's "Fifty-Year Club."

He was named Manitowoc's "outstanding citizen" in 1948 and an award was presented to him for not only being active in civic affairs but also for his service as medical director at the Manitowoc County Hospital.

He had been a member of the teaching staff at Holy Family Hospital, and also had been past president of the Manitowoc County Medical Society and president of the Holy Family's medical staff in 1940. Doctor Hammond was also a member of the American Medical Association.

Surviving are his widow, Leona; and a son, Dr. Reginald, Manitowoc.

Dr. Thaddeus D. Smith, 85, former Neenah physician, died May 9, 1969, in La Jolla, Calif.

Doctor Smith was born Sept. 1, 1883, in Booneville, N.Y., and graduated from the Syracuse University Medical School in 1908. He interned at St. Luke's Hospital, Utica, N.Y., and took postgraduate training in New York City, Vermont, and Rochester, Minn.

He practiced in Neenah from 1911 until his retirement in 1958 when he moved to California. His special interest was industrial surgery and some of his cases made medical history before the Industrial Commission.

Doctor Smith served in the United States Army Medical Corps in World War I and was the first American officer wounded in France on Sept. 4. 1917. During World War II he became ranking officer of the Wisconsin State Guard. He was one of 70 men in the country selected by the Secretary of Defense for the National Defense Orientation Committee.

He was the oldest honorary staff member of Theda Clark Hospital in Neenah and at one time was its chief of staff. In 1958 he was honored by the State Medical Society for his half-century as a practicing physician.

He was a former member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Fredrica, San Diego, Calif.; and two physician sons, Dr. Robin Smith, a pediatrician at Canoga Park, Calif., and Dr. Gregory C. Smith, an obstetrician in Scottsdale, Ariz. □

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

LUNG CANCER—A Study of Five Thousand Memorial Hospital Cases.

Edited by William L. Watson, MD, Emeritus Chief, Thoracic Service, and Attending Surgeon, Special Surgical Service, Memorial Hospital for Cancer and Allied Diseases. C. V. Mosby Company, St. Louis, Mo., 1968. 584 pages. Price: $29.50

MORRIS FISHBEIN, M.D.—An Autobiography

Doubleday & Company, Inc., Garden City, New York, 1969. 505 pages. Price: $10.00

INTRODUCTION TO MEDICAL SCIENCE

By Clara Gene Young and James D. Barger, MD, FACP. C. V. Mosby Company, St. Louis, Mo., 1969. 295 pages. Price: $7.95

MEDICAL INTERVIEWING—A Programmed Manual

By Robert E. Froelich, MD and F. Marian Bishop, PhD, MSPH. C. V. Mosby Company, St. Louis, Mo., 1969. 116 pages. Price: $4.75

MEDICAL SUPPLY IN WORLD WAR II

Prepared and published under direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army. Editor-in-Chief, Col. Robert S. Anderson, MC, USA; Editor for Medical Supply, Charles M. Wiltse, PhD, LittD. Office of the Surgeon General, Department of the Army, Washington, D.C., 1968. Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. 662 pages. Price: $8.25

PUBLIC HEALTH STATISTICS—WISCONSIN 1967

Division of Health, Department of Health and Social Services. Bureau of Health Statistics, Section of Statistical Services, P. O. Box 309, Madison 53701. 96 pages

PROGRESS AGAINST CANCER 1969—A Report by the National Advisory Cancer Control

U. S. Department of Health, Education, and Welfare. Public Health Service/National Institute of Health/National Cancer Institute. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 83 pages. Price: $1.50

PERSONS HOSPITALIZED BY NUMBER OF HOSPITAL EPISODES AND DAYS IN A YEAR—United States—July 1959—June 1966

U. S. Department of Health, Education and Welfare. Public Health Service. Series 10, No. 50, U.S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 50 pages. Price: 55¢

BOOK REVIEWS

MILD MENTAL RETARDATION: A GROWING CHALLENGE TO THE PHYSICIAN

Formulated by the Committee on Mental Retardation. Vol. VI, Report No. 66, September, 1967. Published by Group for the Advancement of Psychiatry, 104 East 25th St., New York, New York 10010. 64 pages. Price: $1.00.

This monograph, produced by a distinguished group of psychiatrists, is directed to the practicing physician. It is an easily readable volume that may also be useful to allied professions and to at least one group of parents. Its theme is the problem of mild mental retardation—a problem whose exact proportions are difficult to estimate but which may involve as many as two to three percent of the population. Until recently, very few of these individuals were brought to the attention of the private physician but, with new federal programs, the medical profession will increasingly be involved in their care.

The monograph summarizes in clear terms current thinking about the problem. There is little in the way of specific information and the reader who hopes to find a digest of new research findings will be disappointed. The report is organized around a distinction between two major groups of the mildly retarded. While the authors avoid the use of labels and refer to them as groups A and B, they have, in the past, been distinguished by such terms as socio-culturally deprived and minimally brain-damaged. Four sections consider the problems of Diagnosis and Psychopathology, Etiology and Prevention, Treatment, and the Law. The distinction between the two groups of retardates is shown to be of practical importance for each of these problems. Throughout, the role of the physician is viewed from two vantage points—as the professional person most likely to provide continuity in the care of the patient and as an influential member of the community.—FRANCES K. GRAHAM, M.D.

THE MEDICAL MESSIAHS: A SOCIAL HISTORY OF HEALTH QUACKERY IN TWENTIETH-CENTURY AMERICA

By James Harvey Young, Princeton, N. J. Princeton University Press. 1967. 460 pp. $9.00.

"When an untrue or misleading health claim is deliberately, fraudulently or pretentiously made for a food, drug, device, or cosmetic, this is quackery . . .

"It matters not whether the quackery is practiced by the witch doctor or the licensed medical practitioner; the Indian medicine man or the pharmacist; the proprietary drug manufacturer or the prescription drug manufacturer; the health-food manufacturer or the clerk in the healthfood store; the health lecturer, the self-styled nutritionist, the doorstep diagnostician, the fly-by-night operator or some of our most respected food, drug, and cosmetic manufacturers—it is still quackery.

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"It matters not which mask it wears—ignorance, superstition, fear, gullibility, folklore, myth, half-truth, or falsehood—it is still quackery."

This definition belongs to Dr. K. L. Milstead, a Food and Drug Administration official. It covers the

waterfront. So does *The Medical Messiahs*, which chronicles the federal government's attempts since 1906, the year of the first food and drug law, to eliminate quackery. Sounds dull? It's not. Professor Young has done a masterly job in combining flavor and documentation to tell this story. He has recreated the settings and the facts of a number of celebrated cases (the Kaadts, Mrs. Drown, Hohensee, Dr. Hoxsey, and others) to demonstrate the interplay of law, lawmakers, violators, enforcers, and the public.

Cases Described

The awful truth is that quackery is as prevalent today as ever. Throughout the years federal and state laws have been tightened, but still there are ways of evasion. Formal prosecution is often extremely difficult and, when successful, frequently unrewarding. The offender is rarely jailed. After paying his fine, his tendency is to start a new venture, perhaps more damaging than the last.

Professor Young has taken great pains to describe these problems in the various cases he presents. The reader can feel the frustrations the government and its experts must have had; but it is also quite clear from the book how well our judicial system works for the protection of those initially presumed innocent.

This leads me to believe that laws alone will not abolish quackery. Education of the public is the only way to make real headway. Articles, lectures, and the like have been tried with limited success.—DON HARPER MILLS, M.D., J.D., Associate Clinical Professor of Forensic Medicine and Pathology, University of Southern California. □

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Dohearty, William H., Milwaukee County, Mar. 26, 1969
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Diabetes Detection Programs

Communities and states participating in short- and long-term diabetes detection programs are reporting great success in discovering unknown diabetics, according to the April–May issue (Vol. 1, No. 6) of the **Disease Detection Newsletter.** The Newsletter is published by the Disease Detection Information Bureau in Chicago.

Oklahoma reports that blood tests of 4,610 persons screened in 28 counties in 1968 uncovered 148 potential diabetics. Physician diagnosis confirmed that 74 have the disease. In a one-week drive in Oklahoma City, abnormally high blood-sugar levels were found in 705 of the 10,400 persons screened. These possible diabetics have been referred to their own physicians for further testing.

Out of 6,121 persons who had their blood tested in 1968 in Broward County, Fla., 100 were referred to their physicians, who then confirmed 27 new cases of diabetes.

In the last six months of 1968 there were 408 persons who visited the Lee County (Dixon), Ill., Why Wait? diabetes screening center to have their blood tested. Twenty-four were retested by their own doctors and 15 were found to be diabetic.

And in Delaware there were 2,531 residents screened in 1968, the second year of a state-wide Why Wait? diabetes detection program. The 102 persons with abnormally high blood sugar levels were referred to their own physicians for further testing.

Why Wait? diabetes detection programs are sponsored nationwide by the Disease Detection Information Bureau of Chicago.

Communities interested in initiating a Why Wait? diabetes detection program can qualify by meeting four requirements: Blood testing techniques which are approved by the local medical community must be used. Screening must be conducted under the direction of a physician. Positives must be referred to their private physicians for diagnosis and treatment. And records must be maintained to obtain statistical results of both testing and physicians' diagnoses.

Information is available from DDib, 3553 West Peterson Avenue, Chicago, Ill. 60645. □

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Aug. 2–3: State Medical Society Council meeting.

Aug. 11–15: Fourth Workshop for the Treatment of Scoliosis and Round Back with the Milwaukee Brace and Exercises in the Brace, Orthopaedic Department of Marquette School of Medicine in cooperation with Milwaukee Children's Hospital, Milwaukee.

Sept. 4: Postgraduate course—The Dentist and Cancer Control, University of Wisconsin Medical Center, Madison.

Sept. 11–14: Annual Meeting, Wisconsin Society of Internal Medicine, Kaehlers Resort (formerly Uphoffs') Lake Delton (changed from Deer Park Lodge).

Sept. 14–16: Wisconsin Pharmaceutical Association 89th annual convention, Wisconsin Dells.

Sept. 26–28: Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Dell View Hotel, Lake Delton.

Sept. 27: Fifteenth annual fall cancer conference (Cancer Scrimmage—Wis. vs. UCLA), University of Wisconsin Medical Center, Madison.

Oct. 1: 4th annual Symposium of Adolf Gundersen Medical Foundation and Wisconsin Heart Association entitled "Acute Myocardial Infarction," La Crosse.

Oct. 3–4: Annual meeting, Easter Seal Society of Wisconsin, Beaumont Motor Inn, Green Bay.

Oct. 6–10: Wisconsin Work Week of Health, State Medical Society, to be held each day in a different city: Eau Claire, Wausau, Green Bay, Milwaukee, and Madison.

Oct. 8–9: Annual meeting, Wisconsin Academy of General Practice, Holiday Inn No. 2, Madison.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton–Schroeder Hotel, Milwaukee.

1969 NEIGHBORING STATES

Aug. 6–8: Seminar in Neurology, Neuroradiology, and Neurosurgery, Minneapolis VA Hospital, Minneapolis, Minn.

Aug. 10–15: American Congress of Rehabilitation Medicine, Chicago, Ill.

Aug. 17–22: American Congress of Physical Medicine and Rehabilitation, Chicago, Ill.

Aug. 18–21: American Hospital Association, Chicago, Ill.

Sept. 14–20: College of American Pathologists, Chicago, Ill.

Sept. 14–21: American Society of Clinical Pathologists, Chicago, Ill.

Sept. 15–16: Biennial meeting of State Medical Journal Advertising Bureau, Chicago, Ill.

Sept. 22–23: Midwest Interprofessional Seminar on Diseases Common to Animals and Man, Memorial Union, Iowa State University, Ames.

Oct. 4–10: Annual Otolaryngologic Assembly of 1969, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Oct. 10–11: American Society of Ophthalmologic and Otorhinolaryngologic Allergy, Chicago, Ill.

Oct. 11–12: American Association of Ophthalmology, Chicago, Ill.

Oct. 12–17: American Academy of Ophthalmology and Otolaryngology, Chicago, Ill.

Oct. 15: Fifth annual professional symposium on Recent Advances in Renal Disease, Kidney Foundation of Illinois, LaSalle Hotel, Chicago.

Oct. 16–17: American Association for Automotive Medicine, Mayo Auditorium, Minneapolis, Minn.

Oct. 18–23: Annual meeting, American Academy of Pediatrics, Palmer House Hotel, Chicago.

Oct. 29–30: American Association for the Study of Liver Disease, Chicago, Ill.

Oct. 29–Nov. 2: American College of Chest Physicians, Chicago, Ill.

Nov.: American Society of Therapeutic Radiologists, Chicago, Ill.

Nov. 2–5: International Symposium on Atherosclerosis, Chicago, Ill.

Nov. 3–14: Postgraduate course in Laryngology and Bronchoesophagology, Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago.

Nov. 8–9: North Central Medical Conference, St. Paul Hilton, St. Paul Minn.

Nov. 11–15: American College of Preventive Medicine, Detroit, Mich.

Nov. 21–22: Workshop on the Delivery of Medical Care in the 1970s, Institute of Medicine of Chicago, Ambassador Hotel, Chicago.

Nov. 28–29: Head and Neck Radiology Conference, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Nov. 30–Dec. 5: Radiological Society of North America, Chicago, Ill.

1969 OTHERS

Aug. 11–15: American Bar Association, Dallas, Tex.

Aug. 11–16: General Practice Review, University of Colorado School of Medicine, Denver, Colo.

Aug. 11–17: Postgraduate course—Space Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 14–16: Postgraduate course on Peptic Ulcer, American Gastroenterological Association, Aspen, Colo.

Aug. 24–29: 8th International Congress of Gerontology, Washington, D. C. (9650 Rockville Pike, Bethesda, Md. 20014; tel. 301/530-3200)

Aug. 28–29: International Symposium—The Impact of Drug Legislation on the Drug Industry," Gottlieb Duttweiler Institute, Zurich, Switzerland.

Sept. 5–7: Cardiovascular Symposium, Tidewater Heart Association, Williamsburg, Va.

Sept. 8–12: Fifth International Congress of Dietetics and 52nd annual meeting of American Dietetic Association, Sheraton–Park Hotel, Washington, D.C.

Sept. 24–26: Cleveland Course in Pulmonary Diseases, Case Western Reserve University School of Medicine in cooperation with St. Luke's Hospital, American Thoracic Society, and others, Cleveland, Ohio.

Sept. 28–Oct. 3: Annual meeting Michigan State Medical Society, Detroit.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 7–11: Western Conference of Prepaid Plans, Sun Valley, Idaho.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 22–24: 16th Western Cardiac Conference, University of Colorado Medical Center, Denver, Colo.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 12–15: Postgraduate conference, Mound Park Hospital Foundation and University of Florida, Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Nov. 20: Annual Membership Meeting, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium). Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psychosomatic Seminars), to South Pacific.

1969 AMA

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

May 11–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 NEIGHBORING STATES

Oct. 5–9: 53rd Annual Meeting, American Dietetic Association, Detroit, Mich.

1970 OTHERS

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1971 OTHERS

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the **Journal of the American Medical Association.**

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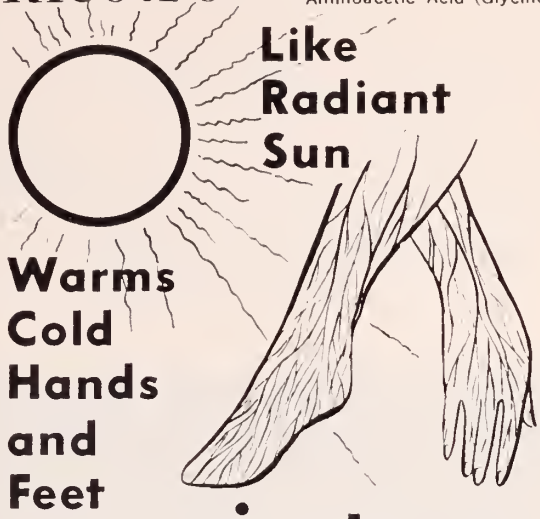

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1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

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Conference on Sex Education—Chicago

"Where Should We Go in Sex Education—A Search for Perspectives" is the theme for a Friday, Saturday, and Sunday, Aug. 15–17, Sex Education Conference at the Conrad Hilton Hotel in Chicago, Ill.

The Comprehensive Medical Society (formerly The International Society for Comprehensive Medicine) is sponsoring the conference as a part of its program of continuing education.

Conference inquiries should be addressed to: The Comprehensive Medical Society, 360 North Michigan Ave., Suite 1003, Chicago, Ill. 60601, Attention: Jessie Potter; tel. (312) 332–0792 or 346–7133.

Pediatrics Conference—University of Iowa

Physicians attending a Pediatrics Postgraduate Conference at The University of Iowa Sept. 10 and 11 will learn more about cardiac examination and pediatric cardiac problems with the help of a cardiac simulator.

The simulator, a computerized electronic apparatus which produces heart sounds and murmurs, provides characteristic auscultatory findings in a variety of disease states for participants listening on headphones.

The session on pediatric cardiology will be among small group discussions and demonstrations which also will cover neurologic problems, ambulatory pediatrics, and learning disorders.

Guest faculty members for the conference will be Dr. Floyd W. Denny, professor and chairman of pediatrics at the University of North Carolina; and Dr. William A. Silverman, chief of the perinatology section at the Perinatal Health Center, Children's Hospital of San Francisco.

Among topics Doctor Denny will discuss will be "The Role of Mycoplasmas as Causes of Diseases in Children," "Lower Respiratory Tract Infection in Children," and "Management of Streptococcal Infections in Children." Doctor Silverman will speak on "Temperature, Food, and Growth in the Neonatal Period," "Neonatal Bilirubinosis," and "The Undersized Newborn."

Other program sessions will include discussions of children and cholesterol, cardiac evaluation by computers, and an emergency infant transport system developed at The University of Iowa.

Conference registration forms and further information on the program and guest accommodations can be obtained by writing: Director of Postgraduate Education, The University of Iowa College of Medicine, 100 F Westlawn, Iowa City, Iowa 52240.

COMING CONFERENCES AT THE UNIVERSITY OF IOWA

Sept. 19–20	Great Plains Regional Heart Meeting
Oct. 3– 4	Urology
Oct. 17–18	General Practitioner's In-House Refresher
Oct. 23–25	Surgery

Occupational Health—St. Louis

The 29th annual AMA Congress on Occupational Health will be held in St. Louis, Mo., Sept. 15–16.

Presentation of the annual Physician's Award of the President's Committee on Employment of the Handicapped will be held Tuesday morning followed by a luncheon at which Dr. Charles A. Berry will speak on "U.S. Man on the Moon." Doctor Berry is Director of Medical Research and Operations, NASA Manned Spacecraft Center, Houston, Tex.

The AMA Council on Occupational Health Advisory Conference with state and county occupational health representatives will meet on Sunday, Sept. 14, with the Council on Occupational Health.

The program is acceptable for 10½ elective hours by the AAGP. There is no registration fee. Further details may be obtained from the Council on Occupational Health, AMA, 535 North Dearborn St., Chicago, Ill. 60610.

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While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

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Before prescribing, please consult complete product information, a summary of which appears on opposite page.

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Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.

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Neuromuscular Diseases—New York

The New York University Medical Center, Department of Rehabilitation Medicine, is offering a full-time course on Clinical Electrodiagnosis of Neuromuscular Diseases Nov. 11–14.

The course is designed to present the basic principles underlying electromyography and nerve stimulation studies to the physician or PhD planning to specialize in clinical neurophysiology as well as to the allied group of physicians who rely on the results as an aid in diagnosis—the neurologist, neurosurgeon, orthopedists, physiatrists, and others.

Registration is limited. Tuition fee: $150.00. Further details: Joseph Goodgold, MD, Institute of Rehabilitation Medicine RR221, 400 East 34th Street, New York, N. Y. 10016.

Pharmacology/Dermatology—New York

General principles of drug action, factors influencing drug response, and percutaneous absorption will be discussed in depth at a three-day symposium at New York University School of Medicine on "The Pharmacology of Selected Drugs Used in Dermatology: Principles of Action and Uses."

Jointly sponsored by the departments of dermatology and pharmacology, the symposium will be held Oct. 29–31, 1969, in Alumni Hall, New York University Medical Center.

The final day, Friday, Oct. 31, will be devoted to the presentation of current information about the action, uses and effects of corticosteroids, cytotoxic and immunosuppressive drugs. Experiences with and the known pharmacological action of such selected topical agents as vitamin A acid, estrogens, testosterone and antiandrogens will also be presented. A question and answer period at the close of each session will provide for audience participation.

Detailed information may be obtained from: The Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, N.Y. 10016, tel. (212) 679-3200, Ext. 2024.

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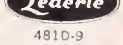

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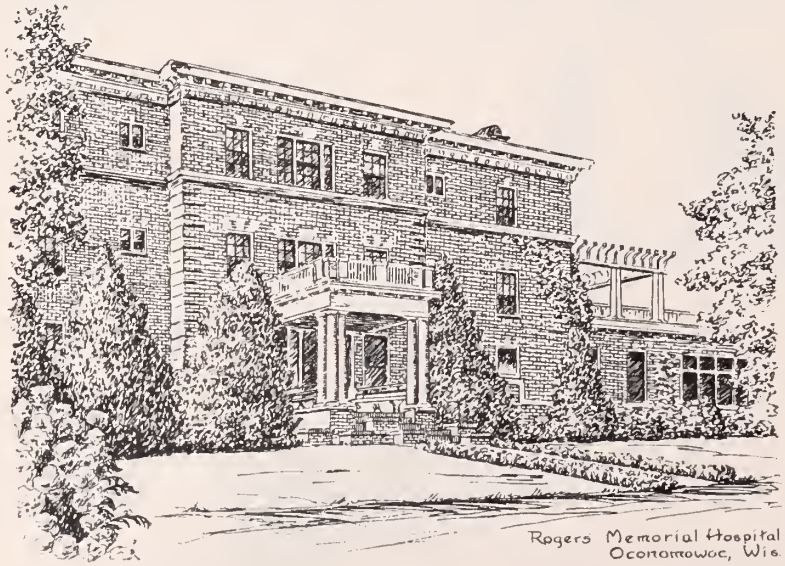

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PRESIDENT'S PAGE

ROBERT E. CALLAN, M. D.

The State Medical Society Has a Purpose And It Has Objectives

It is an old lesson—a worthy purpose, patient energy for its accomplishment, a resoluteness undaunted by difficulties, and then success.

—W. M. PUNSHON (1824–81)

AT ITS 1959 SESSION, the House of Delegates of the State Medical Society of Wisconsin directed that each future session be opened with the reading of Article II of our Constitution, entitled "Purpose." It has been my privilege as a former speaker to have read the purposes of our Society on ten occasions to the great majority of our 268 delegates and alternate delegates, our 21 councilors, the 6 officers, the 10 delegates and alternate delegates to the AMA, who usually were on hand, along with some past presidents of SMS, officers and representatives of our 54 county medical societies, and individual members. If the Society is to serve its membership with maximum effectiveness and efficiency, it is essential that its philosophy and objectives be well understood and accepted by all of our 4,131 members.

The philosophy and the ultimate and specific objectives of our Society as stated in the Constitution were depicted by a Management Survey taken in 1963.

PHILOSOPHY AND ULTIMATE OBJECTIVES

One. To make the medical profession more useful to the public in prevention and cure of disease and in prolonging and adding comfort to life.

Two. To make the profession more capable and honorable within itself.

SPECIFIC OBJECTIVES

One. To federate and bring into one organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association.

Two. To extend medical knowledge and advance medical science.

Three. To elevate the standard of medical education.

Four. To secure the enactment and enforcement of just medical laws.

Five. To promote friendly intercourse among physicians.

Six. To enlighten and direct public opinion in regard to the great problems of state medicine.

The Society's philosophy and objectives appear to be comprehensive and fully adequate to meet present needs even though our Society originated in 1841, seven years before Wisconsin was admitted as a state and six years before the AMA was founded. We must be alert to the rapid changes occurring around us, and a constant effort must be made to better serve the public, adopting new additional goals or revising old ones when indicated.

We have sought through the years to implement these purposes, and as of now, committees address themselves to each of our stated objectives. You are well aware of the great contributions that the State Medical Society has made to the health and well-being of our State and Nation. From a simple small medical society of a dozen physicians to a complex institution of 4,131 physicians we have evolved to this point in space when our purposes and objectives might be obscured by the deluge of criticism directed at the medical profession and all traditional institutions. It is noteworthy to point out, however, that our unselfish purposes remain unaltered. As your President, I will not apologize for medicine.

In these days, the accent is on change and the trend is to consider the patient-physician relationship as a temporary impersonal consumer–provider situation, devoid of the moral and philosophical foundations, and devoid of the personal physician trusteeship that is such an integral part of medicine. More and more, man and disease are treated as statistics in a systems analysis approach.

Since our Society is now large and complex, many physician members may feel apathetic and estranged as they believe they have no personal involvement. Our attendance records at County and State Medical Society meetings certainly may reflect this attitude.

To counteract this, we must repeatedly restate our purposes and objectives. Because all institutions must be geared to the individual members, a critical appraisal of our own Society is good medicine. We need no extensive management surveys; we have but to periodically measure the effectiveness of our efforts against our objectives and purposes. All institutions gather moss in time and have to be renewed periodically. These are changing times—and we must keep up with the times. This makes for greater complexity, size, and expense. Our Council must therefore determine priorities so that we may make the most effective use of our resources.

If we truly adhere to our "Purpose," the sensible majority of the public will aid our cause, for in a deeper sense it is their cause. So let us meet the challenge, keeping in mind the observation of John W. Gardner, former secretary of Health, Education and Welfare:

> *We are producing the most educated, articulate and brilliant sidewalk superintendents the world has ever seen. We have a limitless supply of people with the intelligence and expertise to analyze the society's problems, but very, very few with the motivation and stamina to leap in and help solve them.*

Robert E. Callan MD.

EDITORIAL reprinted from Bulletin of National Tuberculosis and Respiratory Disease Association, November 1968

A MORE DYNAMIC TREATMENT OF TUBERCULOUS INFECTION

IS A MORE DYNAMIC TREATMENT of tuberculous infection indicated? This is a question about which there is considerable controversy. Its answer depends upon several factors.

First, how do we determine the presence of tuberculous infection? The best and simplest way is to do a tuberculin test.

Secondly, what constitutes a positive tuberculin test? Though experts agree that reactions to the test which measure 10 mm or more in the diameter of induration are positive, they admit that some of the smaller reactions may also be the result of tuberculous infection. The area of erythema, or redness, is disregarded.

The next factor to consider is the material to be used for the test. Here again, there is variation in practice. How can results be compared when doctors use first strength Purified Protein Derivative, second strength PPD, intermediate strength PPD, or Old Tuberculin—all in various dilutions? Years ago if a patient was negative to a test with first strength PPD, he was then given the second strength PPD. For most purposes it would seem advisable to adopt one test as the standard and discard the others. PPD intermediate strength, known as 5 TU (tuberculin units), seems the most logical to use for a single test, with 10 mm or more induration as the criterion for designating the test as positive.

There was a time when most adults in this country had a positive tuberculin test, and this is still true in many parts of the world. Today, however, this is no longer the case in the United States, and, therefore, the test is much more important here than it used to be and should be used more often by all family doctors.

The next question is what should the physician do when he finds a positive tuberculin test? The NTRDA-ATS Ad Hoc Committee on Chemoprophylaxis has in a special report suggested priorities for those reactors who should be treated with isoniazid. The report was carried in the September 1967 *American Review of Respiratory Disease* and the October 1967 NTRDA *Bulletin*. Among the positive reactors for whom chemoprophylaxis is recommended by that committee are the following:

1. Persons with inactive tuberculosis.
2. Special clinical situations, including corticosteroid treatment; gastrectomy; reticuloendothelial disease such as leukemia or Hodgkin's disease; presence of unstable, severe diabetes; and other special clinical situations.
3. Contacts of new active cases of tuberculosis.
4. Recent converters.

However, the important pearl of this report is the part that states: "Every positive reactor is at some risk of developing disease. Thus, any person found to have a reaction of 10 mm or more to the Mantoux test, using 5 TU of PPD, should receive chemoprophylaxis whenever he is identified."

Though some might argue that this is not medically warranted because the risk of disease is small, not practical because the drugs do not produce a certain enough effect or because there may be some untoward reactions, I do not believe that these arguments are valid. The NTRDA-ATS statement expresses a principle that must be our goal if we are to effect a more rapid elimination of tuberculosis.

It is recognized that in the United States the majority of active cases of pulmonary tuberculosis today come from the reservoir of people whose tuberculin test is positive. Therefore, why not treat all people who have a positive tuberculin test and who have never had any drug therapy?

It is my feeling that treatment of these people will be universal in this country before too long and perhaps sometime throughout the world.

JOHN L. GOMPERTZ, M.D., President
National Tuberculosis and
Respiratory Disease Association

Available upon request: "Recommendations on Use of Tuberculin Tests and Chemoprophylaxis in Tuberculosis Control Programs of Public Health Agencies" published by the Wisconsin Division of Health and WATA, January 1969, revision—Wisconsin Anti-Tuberculosis Association, Box 424, Milwaukee, Wis. 53201. □

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Big Money vs Public Health

SINCE THE PUBLICATION of the Surgeon General's report on the relationship between cigarette smoking and lung cancer, it has been obvious to responsible members of Congress that some control over the sale and advertising of cigarettes would be necessary. When the matter was first considered by Congress, the tobacco industry was able to defeat all proposals except the one that made mandatory a mild warning that cigarette smoking may be hazardous to health. It appears relatively inconspicuously on the package.

Meanwhile, the spate of cigarette advertising has continued unabated. At the present time cigarette manufacturers are spending 225 million dollars a year on radio and television alone to promote the use of their products. While it is true that the anti-cigarette forces, notably the American Cancer Society, are making a valiant effort to counteract the impact of cigarette advertising, the weight of wealth is on the side of the tobacco industry. Many young people continue to be enticed into tobacco addiction as the result of image-conditioning produced by very clever radio and television commercials.

The original bill dealing with regulation of the sale of cigarettes is due to expire this year. However, the House passed a bill on June 18 barring any further federal regulation of cigarette advertising for another six years. This occurred in the face of vigorous opposition by the Federal Trade Commission and consumer-oriented congressmen. Once again the lobby of the tobacco industry, working through the congressmen of tobacco-growing states, was able to block even the beginning of federal action deemed essential by many health-care experts. Representative Harley Staggers (D., W. Va.) is quoted as fearing that the Federal Trade Commission and the Federal Communications Commission may assume a power never intended by Congress. He said that decisions affecting what may be broadcast, and the way "legitimate" articles of commerce may be advertised, should not be left to "agencies not responsible to the people of the nation."

The matter is not entirely settled yet. The Senate must pass on the bill, and Senator Frank E. Moss (D., Utah) has already denounced the House action. He has indicated that his adherents are prepared to filibuster against an equally pro-cigarette bill in the Senate. It appears certain that the tobacco interests will have a tougher time in the Senate, and that there will be some modification of the House measure in the final conference.

The National Association of Broadcasters views the proceedings with some alarm. If the FTC and the consumer interests prevail in the Senate, the members of the association stand to lose a sizable chunk of advertising revenue. So the joint board of directors of the group recently instructed the radio and television code review boards to reconsider the provisions applicable to cigarette advertising. While the directors did not give specific directions to the code review boards, a plan

offered by the National Broadcasting Company seemed to gain considerable popularity.

Under the NBC plan, radio and television time would be available only to those brands of cigarettes constituting the 20% to 25% of the lowest tar and nicotine yields, as reported by the FTC. The denial of commercial time would occur gradually over a period of years, thereby serving the public interest by encouraging cigarette manufacturers to market cigarettes that would pose less hazard to health. Theoretically, production of "safer" cigarettes would be forced in order for the manufacturers to assure themselves the opportunity to make use of the most effective medium of sales promotion.

As it happens, however, only a few major brands spending big money on radio and television would be penalized—even today—under the NBC plan. Most of the high-yield cigarettes are brands that are seldom, if ever, advertised on radio and television. Among them are English Ovals, Players, Fatima, Colony, Omar, Picayune, Half-and-Half, Stratford, Domino, and Gauloises Caporal. A few, such as Winston 100 mm, Camel non-filters, Tareyton king-size, are already at the bottom of the list of the worst offenders, and in a short time could easily conform to the plan.

From the point of view of the broadcast industry, the NBC plan would permit the present high level of cigarette advertising spending to continue while the media assumed a stance of great public interest.

To those interested in public health, the evasion of a clear-cut duty by the House of Representatives is a shocking dereliction of responsibility. The statement attributed to Rep. Albert W. Watson (R., S. C.) that "there is absolutely no evidence or testimony whatsoever that they (tar and nicotine) produce lung cancer" is a cynical distortion. The specious devotion to the principle of limiting the policy-making power of federal regulatory agencies just doesn't make sense when it is remembered that this devotion surfaces only in connection with a product that has the backing of a powerful lobby. When it is a question of a money crop in the state, morality triumphs over public health.

The failure of the National Association of Broadcasters to take a forthright stand on the issue in the face of possible loss of revenue indicates the moral bankruptcy of the radio and television industry. Broadcasters know as well as any one that little progress will be made in reducing the number of cigarette smokers as long as the use of cigarettes is glamorized and promoted as a smart, sophisticated practice.

If the Congress and the broadcast industry are serious about their interest in the reduction of lung cancer, heart disease, and other possible morbid effects of cigarette smoking, they will take radical action to reduce the sales promotion of the product. No half-way measures will suffice.

Hopefully enough pressure will develop in the rest of the country outside the tobacco-producing states to get some effective legislation on the books. Hopefully, too, the broadcast industry will rise to its responsibility to stop promoting a health hazard. When that happens we can look for a meaningful reduction in the incidence of disease caused by cigarette smoking - - and not before.—D.N.G. □

DR. JAMES NELLEN: New President of UW Regents

In electing Dr. James Nellen of Green Bay as its new president, the University of Wisconsin Board of Regents has recognized a man with a lifelong interest in the welfare of the university as well as having made a judgment on the work he has done since his appointment as a regent in 1965.

Dr. Nellen spent his boyhood in Madison. He enrolled at the university and received his doctor of medicine degree there in 1939. During his years at the university, Dr. Nellen won two letters as a lineman on the Badger football team, perhaps a bit of history which now will help the university's objective of improving its lot on the gridiron.

During his tenure as a regent, Dr. Nellen has demonstrated a quiet capacity for getting at the heart of problems. He may be a soft-spoken member of the board, but his recommendations have come with great thought in an age when some schools are being harmed by heated exchanges which do not hold up in fact.

Northeastern Wisconsin can draw particular satisfaction from Dr. Nellen's election, not only because of his residence but because of the more important place the region now has in university affairs because of the new University of Wisconsin–Green Bay. We do not expect Dr. Nellen to play any favorites in this regard, but his voice will be an important one in a high place.

Dr. Nellen has risen to one of the highest places a citizen public servant can reach at a most difficult time for higher education, both because of fiscal problems and social turmoil on the campuses. The community congratulates him and wishes him well.

—Reprinted from GREEN BAY PRESS–GAZETTE

MEDLARS Demand Search Service and the Wisconsin Physician

By VIRGINIA HOLTZ, Madison, Wisconsin

MEDLARS is a familiar sounding acronym to people in the health sciences. But for many it conjures only vague images of large computer complexes, intriguingly remote fortresses of information, or mystic combinations of machines and data which are somehow impressive but unapproachable. In fact, while still in its infancy, and far from being all-things-to-all-people even in its chosen field, the Medical Literature Analysis and Retrieval System (MEDLARS) can be a very helpful and down to earth aid in storing, analyzing, and retrieving bibliographic citations to biomedical information.

MEDLARS Is . . .

The MEDLARS "memory" is made up of magnetic tapes which currently store well over half a million citations to articles in biomedical journals and serials. Since about 2,400 such periodicals are being indexed, additional citations are being fed into the system at a rate of about 200,000 annually.[1]

Each citation entry consists of the names of the first three authors, the title of the article in English and in the original language if the item is from a foreign language journal, the journal name, volume number, inclusive paging, and date, as well as a note indicating the language in which the article is printed (if other than English). It also includes the subject tags which describe the contents of the article. The number of subject headings assigned depends upon which of two categories the National Library of Medicine has applied to the particular journal: "depth" or "nondepth." Articles from the former average ten headings while the latter average four. These various items make up the body of information which MEDLARS uses in providing its various services.

MEDLARS is a many faceted system. Its primary purpose is the production of the familiar *Index Medicus* and smaller, more specific, derivative bibliographies and indexes dealing with such subfields as toxicity, rheumatology, endocrinology, nursing, and medical education to list a few. These printed indexes, although they are in part computer-produced, are used manually in the traditional fashion.

Miss Holtz is Associate Librarian and Director of the Medical Library Service of Middleton Medical Library, University of Wisconsin Medical Center.

Reprint requests: Medical Library Service, University of Wisconsin Medical Center, 1305 Linden Drive, Madison, Wis. 53706.

* Copies of this form are available from the larger medical libraries in Wisconsin; from the Midwest Regional Medical Library, 35 West 33rd Street, Chicago, Ill. 60616; and from the National Library of Medicine, 8600 Rockville Pike, Bethesda, Md. 20014.

MEDLARS Demand Search Service

Less familiar is the Demand Search Service, available (currently free of charge) to "scientific investigators in public and private institutions, and members of health professions—physicians, dentists, nurses, nutritionists, educators, administrators, medical librarians, and the like."[2]

In response to a demand search request the MEDLARS storehouse of citations is computer-searched to produce a bibliography of periodical articles related to the subject of the original query.

To initiate a demand search, the necessary form* must be filled out by the requester. At this point it is often helpful to consult with a medical librarian who may be able to suggest a simpler approach or advise on the suitability of the request for a computer search. The completed form is then sent to the nearest MEDLARS Search Center where it is used by the staff, in conjunction with their knowledge of the computer complex, the data base and the system, to formulate the search. After various technical maneuvers, the computer searches the citation files for material suitable to the requester's needs.

This is not simply a matter of substituting the machine approach for hand labor as there are some very important differences between the two approaches.

MEDLARS Requires . . .

When using a printed index, the user often clarifies his basic problem as he proceeds with the search, using the nature and quantity of the citations which he finds to modify the scope and direction of his search. This is not possible in a machine search using the MEDLARS System. It is important that the person intending to make use of this service have his subject well defined before approaching the computer. For this reason, it is helpful to consult a printed index, preferably the *Index Medicus* if it is available, in an attempt to define as clearly as possible for the searchers what is wanted. Once the search formulation is finished and tested, it is fed into the computer and the search proceeds along the specified lines with no variation.

Since negative elements can be as important as positive ones, it is essential that any items to be excluded in a search be identified. For instance, a physician studying the general deleterious effects of measles might wish to exclude the large subgroup of articles concerned with the complications of maternal rubella.

MEDLARS Cannot . . .

It is also wise, in preparing a problem for the MEDLARS Demand Search Service, to keep in mind the limitations of the system.

For example, MEDLARS is not designed to retrieve "information" in its raw state. It can, in a humanistic way, "talk" about its own operations, listing how many times certain headings have been used and so forth, but this is the only sort of raw data the system provides. Answers to biomedical questions are furnished in the form of citations to articles which may contain the needed facts.

Since it is a young system, the MEDLARS files do not contain citations to periodical literature published before mid-1963. Earlier literature must therefore be sought elsewhere. Because of the size of the file and the number of requests which must be processed, the current technique is to search only the listings for material published since the beginning of 1966. If this proves to be insufficient the original requester may then ask that the earlier years be searched as well.

Traditional manual tools can still do some tasks more quickly and economically than MEDLARS so it is not available for conducting searches for works of specific authors, for verifying citations, or for doing simple searches for a few articles on a subject or for material which can easily be found under several headings in the printed indexes. For obvious reasons, all search requests for subjects outside the biomedical field are rejected.

Since the computer is still somewhat of an "idiot savant" it is not always capable of responding to requests for material which show certain relationships or express some specific concepts. Those with which it has particular difficulty are:

". . . degree (*high concentrations* of vaccine in the CSF);

. . . time or sequence (radiation *following* chemotherapy; *long term* results of counseling);

. . . qualitative judgments (the *effectiveness* of therapy; *improvement* in economic status);

. . . *acute* or *chronic* conditions."[2]

An example of the sort of difficulties the computer has with relationships is given in a recent study of the Demand Search Service. "The search relates to morphological changes resulting from muscular exercise, including exercise-induced hypertrophy. (The headings) HEART ENLARGEMENT and EXERTION retrieved a number of articles on the effect of exercise on subjects with heart disease and ventricular enlargement (rather than heart enlargement following exercise).[1]

In an effort to prevent the system from becoming overburdened with peripheral material, only the original articles and those letters, editorials, biographies, and obituaries which have substantive content are indexed. Eliminated from the tapes are such materials as abstracts, news items and advertisements, so these classes of printed matter will not be retrieved. Nor will it bring to light nonmedical material from the more general journals included in its list of periodicals indexed, since only those articles of a biomedical nature are cited in the files.

Although machine searching per se is a very fast process, the size and complexity of the system makes it impossible to give immediate service. Queries must be framed in precise terms and the terms interrelated in such a way that the computer will be able to respond efficiently and adequately. Many of these preliminary steps are relatively time-consuming and require the attention of trained searchers who are still in short supply. Therefore, response time for a MEDLARS Demand Search is about one month.

MEDLARS Can . . .

In spite of its failings, this complex of machines and people can provide an incomparable service to health related personnel requiring relatively complete searches of the recent biomedical literature. Not only can it save many man-hours for the busy health scientist by sifting through hundreds of thousands of citations for him but also there are some search tricks which can be done only by the computer.

Because the printed *Index Medicus* would be much too large and expensive if each article indexed were printed out under every assigned subject heading, the indexers at the National Library indicate which headings express the *primary* concepts contained in the articles and which denote peripheral or secondary material. Only the primary topics are represented in the *Index Medicus. All* assigned subject headings are used on the magnetic tape. Therefore even a very thorough hand search of the printed indexes will retrieve only some of the articles dealing with a subject, although these will probably be the major ones. If the inquirer is interested in every article, even if the topic is mentioned only peripherally, then a machine search must be done.

In addition to assigning subject headings to the articles, the indexers also assign a series of appropriate "check-tags." These have to do with the age and sex of patients in clinical reports, the geographic area involved if this is important, the concepts of human studies, animal studies, in vitro research, and so forth. Though these again are not used in the printed indexes, they can be utilized in a machine search. Thus the computer can hunt out those articles, for instance, dealing with a certain disease state in women of a certain age group living in Argentina if that is what the requester wants.

Because each article is indexed under the most specific subject headings available in MEDLARS, material on a complex or broad subject may well require searching under a great many headings. In cases such as this the computer search is definitely more economical in time and money. Not only does the machine hunt out the related articles, but also it easily does the onerous clerical job of transcribing the citations, fully and correctly, on to either paper

or three-by-five index cards. Since it prints not only the citation but the assigned subject headings as well, each citation comes with a sort of telegraphic abstract in the form of its descriptors.

The National Library of Medicine has published several pamphlets and booklets, including the *Guide to Medlars Services,* which are very helpful to anyone wishing to utilize this unique device; and assistance in submitting a search request is available at the larger medical libraries in the state.

REFERENCES

1. U.S. National Library of Medicine: **Evaluation of the MEDLARS Demand Search Service,** Bethesda, Md., U.S. Public Health Service, 1968.
2. U.S. National Library of Medicine: **Guide to Medlars Services,** Bethesda, Md., U.S. Public Health Service, 1968. □

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to : THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

URGES CERTIFICATION OF MEDICAL ASSISTANTS

To the EDITOR:

I was most interested in the following excerpt taken from the article, in the March 1969 MEDICAL GREEN SHEET, entitled "Specially Trained Groups Ancillary to Medicine."

"Voluntary certification of ancillary groups is believed by the State Medical Society to be the most advisable process for recognizing the development of the valued medical care assistant."

It may or may not be known to the members of the State Medical Society of Wisconsin that the American Association of Medical Assistants has had a program of voluntary certification for the past six years.

Currently, there are nine Certified Medical Assistants in Wisconsin.

Taking into consideration the varied duties of the medical assistant, certification may be attained in an administrative or clinical capacity or dually, administrative/clinical, by successfully completing an examination, administered nationally, on the last Friday and Saturday of June, each year. There are various test sites in the United States, including one in Milwaukee.

The examination is not intended to be an evaluation of current job efficiency but covers a broad range of material with which a medical assistant should be familiar.

The examination is prepared by a Test Construction Committee and is supervised by a Certification Board consisting of seven Certified Medical Assistants, three physicians, an educator, and an attorney from the AMA Legal Department. Another educator serves as Test Consultant and reviews all questions proposed by the Construction Committee.

This program is partially financed through an annual cash grant from Merck Sharp and Dohme.

Since the State Medical Society of Wisconsin has gone on record as favoring voluntary certification, may I suggest that its members encourage their employees to give serious thought to becoming certified.

A complete list of rules for eligibility and a study guide to assist in preparation for the Certification Examination may be obtained by writing to: Certification Committee, American Association of Medical Assistants, 200 East Ohio Street, Chicago, Ill. 60611.

CATHERINE T. FUHRMAN, CMA
Certification Information Chairman
Wisconsin State Medical Assistants Society

FORM EMERGENCY PHYSICIANS GROUP

To the EDITOR:

The increasing patient loads in emergency departments across the country has underscored the need for a new type of physician—a specialist in emergencies: the Emergency Physician.

To assist this new breed of physicians the American College of Emergency Physicians was organized in August 1968.

A nucleus of physicians—both from full-time and part-time emergency care groups in Michigan—chartered the American College of Emergency Physicians and have organized the College on a nationwide basis.

At a meeting in Chicago on Feb. 7 and 8, 1969, further steps were taken to widen the scope of the new specialty group. Representatives from 19 states were present to help plan the future of the college.

One of the main purposes of the College is to improve emergency services rendered to the patient. Other aims of the College are: to encourage and implement the training and continuing education of emergency physicians; to promote policy which preserves the integrity of private practice; to promote coordination of community emergency care facilities and personnel; to advance the ethical standards of the private practice of Emergency Medicine and Surgery.

The first and most important order of business is to attract those physicians who are working, full-time or part-time, in emergency departments across the country.

For information write: Executive Secretary, American College of Emergency Physicians, 120 West Saginaw Street, East Lansing, Mich. 48823; or the representative in your area: Richard J. Krill, MD, 8200 North Teutonia, Milwaukee, Wis. 53209.

JOHN H. VAN DE LEUV, MD
Chairman, Publication Committee

ATTENTION . . .

THOSE PHYSICIANS WHO ATTENDED THE STATE MEDICAL SOCIETY ANNUAL MEETING IN MAY AT THE MILWAUKEE AUDITORIUM:

Because the list of physicians requesting our class kit was inadvertently discarded by Auditorium personnel, we have been unable to comply with your requests. We will be very happy to supply you with a class kit if you will send a postcard with name and address to:

Mrs. David R. Hedrich
Natural Childbirth Association of Milwaukee
11420 West Belmar Drive
Hales Corners, Wisconsin 53130

SECTION OPHTHALMOLOGY

JULY 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

EYE BANKS

Dr. Alson Braley from the University of Iowa addressed the National Society for the Prevention of Blindness at its annual meeting in Milwaukee, May 16, on the subject of "Eye Banks and Corneal Transplants."

He reported there are 87 eye banks in the United States. Twenty-seven are supported by Lions clubs, three are supported by state societies for the Prevention of Blindness, and 57 are supported by lodges, community chest funds, or self supporting. Last year 1,000 eyes were distributed through the amateur radio network.

He said he had recently taught a small group of morticians the sterile technique of removing eyes. He was optimistic for more cooperation from morticians in obtaining eyes.

He reported obtaining clear corneal grafts using donor eyes up to seven days old after death.

MARQUETTE RESIDENTS HONORED

A dinner was held at the University Club, Milwaukee, on June 6 for Marquette's graduating ophthalmology residents. Dr. Walter E. Gager, assistant professor of neuro-ophthalmology at Marquette, handled the arrangements.

Five residents are completing their training. Two are entering military service, one is going to Ohio, one is going to Michigan, and the one remaining in Wisconsin is Dr. Gerald W. Wadina who will practice at Cudahy.

WISCONSIN LOSES TWO OPHTHALMOLOGISTS

Dr. Carl W. Aageson, Madison, and Dr. Ralph P. Sproule, Milwaukee, recently died. Doctor Aageson's death is reported in the Obituary section of this issue, and Doctor Sproule's obituary will appear in a future issue.

REPORT FIREWORKS ACCIDENTS

The Wisconsin Society for the Prevention of Blindness, 312 East Wisconsin Ave., Milwaukee, Wis. 53202, asks that any fireworks injuries to the eyes be reported to them.

OLD OPHTHALMOLOGY JOURNALS WANTED

The Section of Ophthalmology at the University of Wisconsin recently has established an ophthalmology library to provide a handy reference library for its ophthalmology residents. Any ophthalmologist who has an accumulation of old ophthalmology journals that he would like to dispose of would find these journals a welcomed gift. The library is located in the Eye Clinic at University Hospitals, 1300 University Avenue, Madison, Wis. 53706.

OPHTHALMOLOGISTS WIN AWARD

A "Special Merit" award was received by Drs. Rodney Strum, John Doty and John Berger for their scientific exhibit on "Corneal Disease and Surgery" at the annual meeting of the State Medical Society of Wisconsin in May at Milwaukee.

MONROE TO GET EYE BANK

Dr. Robert Smith, president of the Monroe Lions Club, recently announced plans to establish an eye bank in Monroe.

DR. BOLGER APPOINTED EXAMINER

Dr. James V. Bolger, Waukesha, has been appointed examiner for the American Board of Ophthalmology. He will start this office at the next board examination to be held in Chicago Nov. 17 to 19. Dr. Bolger is president of the Milwaukee Ophthalmological Society.

VOLUNTARY DUES ASSESSMENT

The executive committee would like to remind all ophthalmologists that voluntary dues for the year 1969 are still being received. The regular membership contribution is $100.

Checks are payable to: Section on Ophthalmology. Mail to: State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MEETING DATES

The next meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology will be held at Dell View Hotel, Lake Delton, September 26–28. For more information contact George L. McCormick, M.D., Secretary, 102 East Main Street, Waukesha, Wis. 53186.

ANNALS OF OPHTHALMOLOGY

Ophthalmologists and members of allied displiplines are invited to submit manuscripts on theoretical, experimental, or clinical subjects to the newly founded ANNALS OF OPHTHALMOLOGY, 30 North Michigan Ave., Chicago, Ill. 60602. Editor: Dr. John G. Bellows. □

WISCONSIN MEDICAL JOURNAL
Vol. 68, No. 7 JULY 1969

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

STORY GOES NATIONWIDE

Broke, Baby Ill, Family Finds a Friend

Reprinted from *St. Paul Pioneer Press*, May 25, 1969

ST. CLOUD (UPI) — Robert Pastain finally found help Saturday after he and his wife had traveled nearly 300 miles in three days with a newborn baby, a 2-year-old daughter and virtually no money.

"It was the first time I'd ever asked for help in my life," the unemployed Graham, Wash., welder said.

Pastain said they had driven from Graham to Flint, Mich., for his mother-in-law's funeral even though he had very little money after being laid off from his job.

As they reached Tomahawk, Wis., on the return trip, Mrs. Pastain began to experience labor pains and they went to the local hospital.

"The people at the Tomahawk hospital told us they could pay for delivery of the baby, but they had no welfare facilities," he said. So they left town two hours after the 8-pound girl was born.

Thursday they ran out of gas, he said, and he traded a watch "worth about $50" for a tank of gas at a small Wisconsin town.

Then about noon Friday Mrs. Pastain noticed a protrusion on the baby's stomach and thought the child was becoming feverish. "So we started trying to get medical attention," Pastain said.

"We stopped at one town in Wisconsin—I can't remember its name and went to four doctors' offices. Their nurses all told us we couldn't see the doctors, because I told them we couldn't pay."

Saturday morning they arrived here, stopped at a snack bar, and then called Stearns County Deputy Sheriff Conrad Braun.

Braun sent mother and child to St. Cloud Hospital and set about finding a place for Pastain and the 2-year-old to stay.

"He can apply for aid when the County Welfare Board opens Monday," Braun said, "and in the meantime they will be cared for. You have to give help before you worry about money and bills."

SOCIETY REPLIES

SMS News Release Gets Nationwide Publicity

The following is the full text of a letter from Dr. Robert E. Callan, president of the State Medical Society of Wisconsin. In the letter, Dr. Callan asks the nation's press to help locate a Mr. Robert Pastain, reportedly of Graham, Wash. The release, issued June 30, 1969, was printed by papers from Seattle, Wash., to Flint, Mich.

Gentlemen of the Press:

On Saturday, May 24, 1969, a story appeared in the ST. CLOUD (Minnesota) TIMES concerning a Mr. Robert Pastain of Graham, Washington, and his family. The story was written by Reporter Bruce Nelson who interviewed Mr. Pastain when the latter requested medical treatment for his infant daughter in St. Cloud. A photocopy of the original story is enclosed.

In substance, Mr. Pastain stated that his baby daughter was born in Tomahawk, Wisconsin hospital just days before, and that the family, including the newborn child, were more or less forced to leave within two hours after the birth because the hospital lacked welfare facilities.

Mr. Pastain testified that further medical treatment for the baby, whom he thought was ailing, was repeatedly denied in several Wisconsin towns along the way because he lacked funds; that in one Wisconsin community alone, nurses to four physicians refused to let him "see the doctors" when they learned he "couldn't pay."

The story of the apparent Pastain plight was carried nationally by all media and received critical attention everywhere.

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PASTAIN FAMILY . . .

continued from page 45

The State Medical Society is most deeply concerned about this alleged incident. For the past five weeks, we have carried on a full-fledged field investigation of the case, following every possible lead.

Our purpose in such an investigation is this: If the incident did happen, our Society, acting on behalf of the physicians of Wisconsin, will take appropriate action to guard against such a deplorable occurrence ever happening again.

If, however, the incident did not occur, then we would be hopeful that this also should be widely known, that the public record would be wholly corrected on the circumstances.

Below are the results of our five-week investigation.

1. Mr. Robert Pastain told Stearns County Welfare Department officials (St. Cloud is located in Stearns County) that at the time of the alleged incident, he and his family were on their way from Flint, Michigan, where they had attended *the funeral of Mrs. Pastain's mother.* His wife's maiden name was given as Doris Davis. However, the State Medical Society of Wisconsin checked with the Genesee County Medical Society in Flint. *It could provide no clue whatsoever* involving a funeral with the names of Davis or Pastain or relatives from the state of Washington attending the funeral. A similar check of the Flint, Michigan newspapers for the period in question (May 12–21) *provided no clue either.*

2. Mr. Pastain told Stearns County Welfare authorities *he was from Graham, Washington;* that his father lives in that city. However, the State Medical Society called E. T. Van Slyke, Postmaster of Graham. He stated that there was *no record of Robert Pastain* or any similar name in or around Graham. He also reported that the Tacoma, Washington Sheriff's Department has also been investigating the whereabouts of Mr. Pastain and that no one of that name in Tacoma could be located.

3. According to Reporter Bruce Nelson, Mr. Pastain stated he lived at Route 4 in Graham, Washington. According to the welfare application he made out, however, Mr. Pastain gave Route 2 as his address. In any event, the State Medical Society learned from the same postmaster that there are only Routes 1 and 2 in the Graham and Tacoma areas. There is no Route 4.

4. Mr. Pastain also recorded *his county of residence* as Benton County, Washington. However, the State Medical Society discovered that Benton County is *300 miles from Graham.* Further, the service station operator who supplied gasoline to the Pastain auto at the request of the Stearns County Welfare Department said the auto *had North Dakota license plates.*

5. Mr. Pastain also listed on the welfare application *his Graham telephone number as 133–R31.* However, the State Medical Society was told by the Graham telephone operator that *no such number exists in the Graham area.*

6. Mr. Pastain also listed *his Social Security Number as 367–23–5324* with the Stearns County authorities. However, the State Medical Society checked with the Wisconsin office of the U.S. Social Security division which reports that *such a social security number does not exist.*

7. Mr. Pastain stated that he called upon the *Wisconsin State Highway Patrol for assistance* when it appeared his wife was in labor. However, the State Medical Society has learned that the Wausau, Spooner, and Eau Claire district offices (through which he normally should have traveled) *have no knowledge of such an event.* Yet, the Highway Patrol *requires* an officer rendering assistance to a motorist to file a report of the incident. The Lincoln County Sheriff's Department also answered in the negative: *They were not asked to help Mr. Pastain.*

8. Mr. Pastain also stated that his baby daughter *was delivered in the hospital in Tomahawk, Wisconsin.* There is only one such facility in Tomahawk, Wisconsin: the Sacred Heart Hospital. However, the State Medical Society learned that *Sacred Heart could not have been involved* in the delivery, nor were any physicians on its staff. There are no records—which are required—of such an incident. Further, the Section of Vital Records, Division of Health, State Department of Health and Social Services of Wisconsin also reported to the State Medical Society that *no record of a Pastain birth has been reported* to it, even though a birth record is a required document.

9. The State Medical Society determined that it was possible that *Mr. Pastain may have mistaken the name of the town* where the birth occurred, citing Tomahawk when he meant Tomah. However, upon check, the Society learned that neither the Tomah hospital nor the area police *has a record or a remembrance of such an occurrence.*

10. According to witnesses, there appear to be even more inconsistencies in the string of events.

But the story, broadly-recorded, lives on. A simply enormous amount of news coverage was given to it. As a result, letters, telephone calls, and other communications have been received in volume by the Sacred Heart Hospital in Tomahawk; by the weekly newspaper there, the TOMAHAWK LEADER; and by the State Medical Society of Wisconsin.

It is a fact that most of these have been extremely critical, even caustic both of hospitals and physicians.

We are trying to piece together the facts of this alleged incident. To do so, we would sincerely welcome the assistance of the nation's press in locating Mr. Robert Pastain or his wife. If the incident did occur, we need their help in documenting it.

continued on page 47

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal,* official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1969 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

SMS Hot Line

BLOOD DONORS BILL PASSES . . . A Society-backed bill to allow minors over the age of 18 to donate blood without parental consent has been signed into law. The legislation was designed to increase whole blood supplies by allowing students to participate in blood drives.

BUDGET BILL INCLUDES MEDICAL EDUCATION FUNDS . . . Money for the planning phase of the UW Medical School expansion is included in the Assembly version of the budget bill. The budget, which has slowed action on other legislation this session, is currently under debate. It is important that physicians urge their representatives to make certain that adequate medical school funds are included in the final compromise proposal.

CHIROPRACTIC DRIVE CONTINUES . . . Chiropractors are seeking inclusion of their services under Medicaid (Assemby Bill 97) and Workmen's Compensation. Both proposals are still under consideration, and these unwarranted attempts at expansion of privileges must be explained to all legislators.

DISPENSING OPTICIANS BILL . . . Society-supported legislation for the certification of dispensing opticians under the Medical Examining Board is under consideration by the Senate. Proper regulation of this ancillary group with medical involvement will serve the health interest of all Wisconsin citizens.

MEDICAL PRACTICE AMENDMENTS OFFERED . . . SMS amendments to the Medical Practice Act will be the subject of a hearing before the Senate Public Welfare Committee in the very near future. These amendments are aimed at updating current regulations and helping solve the State's physician shortage.

LABORATORY LICENSING PROVISIONS SUBMITTED . . . Society-backed amendments to a proposed bill which would license all laboratory personnel have been presented to the Senate. The amendments are keyed to the licensure of laboratories and their directors rather than to all types of laboratory personnel.

IMPLIED CONSENT PASSES SENATE . . . The Governor's proposal for blood alcohol test for individuals suspected of driving while under the influence of alcohol has passed the Senate and is now ready for Assembly action. This legislation includes wording, supported by SMS, which would grant immunity to physicians who are performing the tests required by the proposal.

PASTAIN FAMILY . . .

continued from page 46

If it did not, then many, many reputations have been damaged. Those include the staff of Sacred Heart Hospital, the citizens of the community of Tomahawk, the State Highway Patrol, even the State of Wisconsin, as well as the members of the medical profession, including the other men and women of the health care team.

If you, the Gentlemen of the Press, have any leads whatsoever, please communicate them directly to Mr. Earl R. Thayer, Associate Secretary of the State Medical Society of Wisconsin, P. O. Box 1109, Madison, Wisconsin. (Phone: Area Code 608–257–6781.)

Sincerely,

Robert E. Callan M.D.

ROBERT E. CALLAN, M.D.
President

WISCONSIN . . . is one of four or five states in the United States where maternal mortality rates are distinctly less than 20 per 100,000 live births, or below the lowest rates reported for any country in Europe. The rate for the U. S. as a whole is 28.9, a significant downtrend since 1933 when the rate was 619 per 100,000.

PINCH OF FUNDS is catching. The Wisconsin Crippled Children's Program of the Bureau for Handicapped Children, faced with the financial squeeze of increasing costs and decreasing funds, is appealing to state physicians to hold the line on "customary, usual and reasonable fees." Says the Bureau's medical director, Dr. Horace K. Tenney, III: "We are asking you to keep all charges down to the lowest possible level for this group of handicapped children. In this way we can keep from cutting back too drastically on our programs and, therefore, will be able to help more children."

A NATIONAL HEALTH CORPS, modeled after the Peace Corps, is being urged by Sen. Gaylord Nelson (D., Wis.). "Our young doctors, nurses, and other medical personnel should be given the opportunity to share in the satisfaction of public service through participation" in such a domestic group. Project HOPE already has such a unit operating in Texas on a voluntary basis; may expand into other areas, including Wisconsin.

GOOD NEWS for a change! The Chicago Tribune of June 4, 1969, carried this note in a column called "Tower Ticker" by Robert Wiedrich: "More Good Folks—We, too, found someone with time to spare for total strangers on our own holiday excursion to southern Wisconsin. Would you believe that a doctor named (omitted) took time from his family and holiday to open his office in Fort Atkinson late at night to treat a superficial eye injury? And would you believe that Dr. (omitted) charged only $6.50 for his services, including medicine? We do, now!"

HOW SAFE IS THE SKY BLUE WATER? Wisconsin's public health officials report there is no evidence that disease is transmitted via bathing waters such as swimming pools and beaches, especially if declared "safe" by a fecal coliform test. Members of the SMS Commission on Health and Natural Resources aren't so sure. Several report high incidence of eye, ear, nose infections this time of year among bathers. If you have evidence of such infections or other diseases and believe them connected with swimming waters, please contact the SMS Commission, Box 1109, Madison, Wis. 53701.

U. S. MEDICARE BILL NEARS $6 BILLION . . . with about 30% being payments to physicians. This is the report for the year 1968.

NEWS GUIDE FOR PHYSICIANS, hospitals, and communications media is being readied for publication by the Society's Commission on Health Information. After meetings with representatives of all major news media organizations in Wisconsin (all of whom report generally good relations with physicians), the Commission will make slight modifications in the current guide and distribute to all physicians, hospitals, and media. If you'd like a copy, write to SMS in Madison.

trends

The Wisconsin Regional Medical Program, Inc.

JULY, 1969

WRMP RECEIVES $300,000 AWARD ONE WEEK AFTER ANNUAL MEETING

Dr. Hirschboeck Tells Group Of Tighter Federal Spending

The Wisconsin Regional Medical Program, Inc., (WRMP), received a $300,000 supplementary grant from Washington to cover two new projects, according to Dr. John S. Hirschboeck, program coordinator.

The supplementary grant came just one week after WRMP's annual meeting in Oshkosh. The award allocated $204,345 for a pediatric cardiology project for the Wisconsin Region and $95,655 for a coronary angiography project under the directorship of Dr. Robert M. Green, cardiologist, Lutheran Hospital, La Crosse, who will work in cooperation with the La Crosse County Medical Society.

The $300,000 supplementary grant by no means indicates that federal funds are becoming more available.

At the annual meeting of WRMP, Dr. Hirschboeck explained that federal funds are expected to be very tight for some time to come.

"I certainly hope people don't get their hopes too high with regard to the availability of federal funds," he said. "It is still anticipated we will be hit pretty hard in funding new projects now under review."

Dr. Hirschboeck spoke with reference to the government's cut in federal spending, especially in health, education, and welfare.

WRMP has been appropriated approximately $2 million since it was organized in 1966. If Congress appropriates $74 million for all Regional Medical Programs as anticipated, WRMP will receive minimum funds for operational expenses if the allocations are distributed as they have been in the past among the 55 Regional Medical Programs throughout the United States.

"With the shortage of federal funds, we are going to have to tighten our belts a little without curtailing our efforts of improving patient care in the Wisconsin Region for those suffering from heart disease, stroke, and cancer," he added. "We will have to work all the harder in utilizing the resources available."

New Posts To Kabler, Callan, White; Nadler Honored By Texas Engineers

Drs. Philip T. White, Robert E. Callan and J. D. Kabler were named to new posts recently and Gerald Nadler was honored by a group of engineers in Texas.

Dr. White was named a member of the National Review Committee of the Division of Regional Medical Programs in Washington. He is chairman of the Stroke Study Committee of WRMP and a professor and chairman of the Department of Neurology at the Marquette School of Medicine, Inc.

Dr. Callan, a member of WRMP's Planning Committee, was elected president of the State Medical Society of Wisconsin at its annual meeting in Milwaukee last May. He has been active in WRMP activities since 1966.

An assistant coordinator for WRMP since it was organized three years ago, Dr. Kabler has been named director of the University Health Service, University of Wisconsin, Madison. In his new capacity he will be responsible for the medical needs of the 34,000 students on the University's campus.

Nadler, chairman of WRMP's Planning Committee and chairman of the Industrial Engineering department at the University of Wisconsin, was made a fellow of the American Institute of Industrial Engineers. He was honored for his achievements as an engineer, educator, author and consultant at the society's annual meeting in Houston.

PERSONAL MEDICAL DATA GOES COMPUTER TO IMPROVE CURE RATE OF UTERINE CANCER PATIENTS

Death Rate Minimized Through Early Detection Of Disease

A computerized system of compiling personal medical data of uterine cancer patients is being established on an experimental basis through a program funded by The Wisconsin Regional Medical Program, Inc. (WRMP).

Through the experimental project, the facilities at the Marquette School of Medicine and the University of Wisconsin Medical Center have combined their capabilities. Others included in the system are St. Mary's Hospital, Milwaukee, and the Marshfield Clinic and St. Joseph's Hospital in Marshfield.

Once a most dreaded disease, uterine cancer can be cured if found in an early stage. The U. S. death rate for uterine cancer is declining, less than half the number of cases as compared to 20 years ago.

From all this it may sound like there isn't too much to worry about! This, however, is not the case.

True, new technology is being developed everyday to improve cure rates but such improvement depends primarily upon early detection to minimize the death rate from the disease.

Ben M. Peckham, M.D., chairman, department of gynecology and obstetrics, University of Wisconsin Medical School, Madison, and Richard F. Mattingly, M.D., chairman, department of gynecology and obstetrics, Marquette School of Medicine, Milwaukee, have been working on computer applications in the management of uterine cancer for the past two years. Funded by WRMP, the project includes the staffs of both medical schools along with the staffs of the affiliated hospitals in the program, working in conjunction for a common good.

"We are sure that the treatment of uterine cancer patients can be improved by computer applications which would allow physicians in

DR. MATTINGLY

DR. PECKHAM

widely separated locations to exchange information and ideas," Dr. Peckham said. "The computer provides the necessary common language and completeness of information to allow this exchange without misunderstanding.

"Consequently, we devised our computer program," he continued. "The patient answers questions given to her by the computer. The answers are given directly to the computer for storage and evaluation. This directness and storage capability allows us to evaluate uterine cancer patients with a minimum of error."

The content of the cancer history questions has been limited primarily to material felt pertinent to the patient's known disease, uterine cancer. Detailed questions on the menstrual, reproductive and marital history are included. Specific inquiry is made as to the dates and results of previous Papanicolaou smears, biopsies and dilatation and currettage. The patient is asked whether she has had previous serious medical illness or pelvic surgery. In addition, personal sexual data is requested after an explanation stressing that such data will not be printed on the medical record and will be used only in tabulated form for research purposes.

The questions pertaining to the physical findings are of a more general nature.

"These questions provide, for the medical record, the details of the general physical examination," Dr. Mattingly added. "They include a detailed abdominal and pelvic examination. Both the history and the physical examination data are printed by the computer for inclusion in the medical record.

"After the interview between patient and computer and the examining physician and the computer, the questions and answers are permanently stored on a magnetic tape," he continued. "The questions and answers are readily available through 'print-out' sheets

(Continued on next page)

UTERINE CANCER . . .

which include not only positive points but as many negative statements as may be needed."

The major advantage of the operation of the system is the ability to edit and interview easily permitting a continual improvement of individual questions and printed responses.

To date, more than 125 examinations have been entered. The average amount of time to complete a cancer history is 34 minutes. Resident physicians can complete the questionnaire in 19 minutes.

"Time saving is not considered the major advantage of the system," Dr. Peckham said. "Completeness of the record, legibility and the use of standard terminology are the chief advantages."

So, where do we go from here?

"Regional planning and the development of coordinated efforts among medical centers and other agencies will require the unification of clinical data on a massive scale," Dr. Mattingly explained. "Because of the need for this information to be available on a statewide basis it must be compiled from all areas. Automation is the only way these data can be kept current and accurate."

A thorough and accurate personal history of all uterine cancer patients will aid not only present patients but future patients as well.

Patients with uterine cancer can be reminded as required to see their doctor. Their complications and survival can be quickly determined at any point in time after treatment.

A very important use is the physician's accessibility to computerized dosimetry. The measurement is accurate and easily calculated for immediate use by the physician.

"The ability to tie distant stations together through the use of telephone lines should minimize the need for multiple major computer centers," Dr. Mattingly explained. "Through cooperation, coordination and minimal expense this network could be invaluable to many major medical facilities in the Wisconsin area."

WRMP . . .

A LOOK INTO THE FUTURE

By
JOHN S. HIRSCHBOECK, M.D.
Program Coordinator

Inflation and rising costs are eroding many areas of our economy, and not the least of these to be affected is the health-care system. The cost of occupying a hospital bed ten years ago might have been $20 per day. Today it is $60 or more a day. The bed is probably the same, but what goes with it in service is what makes the difference. The costs of wages, supplies, and maintenance have risen with inflation. Then, add to this the cost of the new technology and the amounts become almost incredible to physicians and hospital workers who remember things as they were thirty years ago. Now add to all of this the new costs which arise out of Medicare and Medicaid, and one can readily appreciate why Congress and the President are deeply concerned about rising health costs and are searching for controls. Answers such as "cut the doctors' fees" or "cut the cost of drugs" make news but do not get at the heart of the matter, because the major cause for increased costs comes from rising wages and requirements to meet higher standards in hospitals and nursing homes.

These higher standards and the improved quality of the service rendered are one form of hidden dividends. There are, however, others which, I believe, merit our consideration. Up until now, Regional Medical Programs have emphasized the improvement of health service in a professional and scientific sense. However, now that the Regional Medical Programs have had an opportunity to demonstrate how they can participate in the health-care system, one discerns that these programs also have the capability to do much to alleviate those pressures which are working to increase costs.

The essential characteristic of Regional Medical Programs is the building of cooperative arrangements to provide better health care. Why not add — "and to reduce costs" — to this statement? If the better utilization of manpower and physical resources can influence the quality of health care, why should we not recognize the hidden dividend of cost abatement through this efficiency? If technology presents us with manpower saving devices which perform as well or better than hands or eyes, Regional Medical Programs should adapt them to the system, not only because quality is improved, but also because there is a dividend in cost abatement as well. If medical science discovers ways to reduce morbidity and mortality, and Regional Medical Programs provide the channel to introduce them into the health-care system, surely here is another dividend in the form of rehabilitation to keep people employed or at least out of hospital and nursing home beds.

The National Center for Health Services Research and Development will find in the Regional Medical Programs an opportunity to cooperate, not only to improve the effectiveness and quality of health service by testing innovations in manpower and facility resource development, but also an opportunity to evaluate cost effectiveness as a corollary to improve health care.

WRMP COMMITTEE ACTIONS . . .

The PLANNING COMMITTEE has been working in cooperation with the Goals Committee of the Regional Advisory Committee in the development of long-range goals and objectives for WRMP. It has also discussed possible changes in the process of proposal development and review . . . The NURSING COMMITTEE has stressed the need for a course for nurse practitioners in intensive care and for inservice education programs for nurses in small hospitals and nursing homes. It has suggested that WRMP should seek further involvement of the minority group and/or disadvantaged health consumer in WRMP programs . . . The POSTGRADUATE EDUCATION COMMITTEE has proposed the development of a "Learning Behavioral Study" with the aim of improving the *quality* of care through the education and change in behavior of those rendering health care . . . The MEASUREMENT AND DATA COLLECTION COMMITTEE has been working chiefly on the Health Resource Data Bank which WRMP has been developing on computers. A print-out of this information is available to anyone who requests it . . . The CANCER STUDY GROUP has been studying pediatric and lung cancers as possible components in a comprehensive cancer program for WRMP . . . The HEART STUDY GROUP has been investigating various electrocardiogram interpretation systems as a preliminary step toward initiating a project in this area. It has also been working on development of a myocardial revascularization proposal and a coronary care consulting program . . . The STROKE STUDY GROUP has been using the Delphi procedure, a method of arriving at priorities through a mailing procedure, to achieve its goal of establishing priorities for developing comprehensive programs for stroke patients.

New WRMP Brochure Available

WRMP has a new brochure available outlining the purposes and activities of the program and how they relate to the people in Wisconsin. The brochure was mailed June 20. Additional copies are available by writing: Peter A. Kirsch, Director, Public Information, WRMP, 110 E. Wisconsin Ave., Milwaukee, Wisconsin 53202.

Trends is published quarterly by The Wisconsin Regional Medical Program, Inc., 110 E. Wisconsin Ave., Milwaukee, Wis. 53202. Articles for publication can be sent to the above address in care of Director, Public Information.

Board of Directors:

T. A. Duckworth, WRMP President, senior vice president and secretary, Employers Insurance of Wausau, Wausau.

Edward J. Connors, superintendent, University Hospitals, Madison.

Dr. Frank E. Drew, past president, The State Medical Society of Wisconsin, Madison.

Orval H. Guenther, director, Milwaukee County Institutions and Departments, Milwaukee. (Retired)

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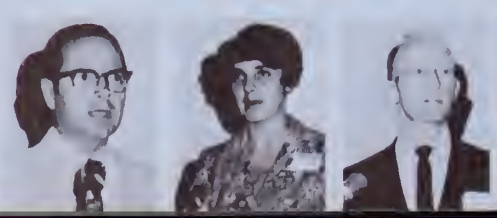
Rev. John P. Raynor, S.J., president, Marquette University, Milwaukee.

WRMP Program Coordinator:
Dr. John S. Hirschboeck

WRMP Director, Public Information:
Peter A. Kirsch

ANNUAL MEETING IS SCENE OF MANY MEETINGS, TALKS

Top Left: Dr. Donald P. Schlueter addressed the Project Review Committee. *Top — Lower Right:* Members of Regional Advisory Committee listen to Chairman Judge Rodney Lee Young. *Lower Left:* Reports were given by Project Directors.



NEWS HIGHLIGHTS

Dr. J. W. Nellen Elected President University of Wisconsin Regents

In mid-June Dr. James W. Nellen* of DePere was elected president of the University of Wisconsin Board of Regents. He succeeded Charles Gelatt, La Crosse, who declined to run for reelection.

An orthopedic surgeon and Green Bay Packer team physician, Doctor Nellen was named a regent in February 1965. He was nominated for the regent presidency by Bernard Ziegler who said that Doctor Nellen would bring to the office "all the ability and integrity anyone could offer and there's no doubt about his straightforward approach."

Dr. Nellen

Mr. Ziegler was elected vice-president of the board.

Subsequent to the election, Doctor Nellen has been authorized to receive clerical help, a car and driver for his use on university business, following a recommendation of his predecessor, Mr. Gelatt.

An editorial from the GREEN BAY PRESS–GAZETTE appears in this issue at page 36.

Wisconsin Hospital in Computer Network

St. Mary's Hospital in Superior is one of nine hospitals in four midwestern states that have established a computer network to improve both patient service and administrative effectiveness.

The hospitals—in Illinois, Indiana, Wisconsin, and Minnesota—are owned and operated by the Poor Handmaids of Jesus Christ, an international Catholic religious congregation with United States headquarters in Donaldson, Ind.

The hub of the new computer network is an electronic system installed at the Association of Ancilla Domini Hospitals in Chicago. The association acts as a central management service for its members and provides purchasing, engineering, and administrative consultation as well as data processing.

Six hospitals are connected to the computer via tele-communication lines and typewriter-like terminals.

Special Clinic for Cardiac Patients

Drs. Thomas C. Meyer* and Richard H. Wasserburger* of Madison in June at Berlin conducted a special clinic for 24 cardiac patients from Waushara, Marquette, Green Lake, and Fond du Lac counties. Patients had been referred by their family physicians for diagnostic work by the two specialists.

Doctor Meyer is a pediatrician and also associate professor in the department of pediatrics, University of Wisconsin–Madison and associate dean of the medical school; Doctor Wasserburger is a cardiologist and internist, chief of cardiology at Veterans Administration Hospital, Madison, and professor of medicine at the UW–Madison.

The clinic has been held annually for over 10 years as a service to the community by the Wisconsin Heart Association with the cooperation of the Green Lake–Waushara County Medical Society. It is one of 19 clinics held annually throughout the state.

The two specialists spoke to the County Medical Society in Green Lake that same day at a noon luncheon, discussing cardiovascular medicine.

PHYSICIAN BRIEFS

Dr. Jerome C. Brooks*

. . . Racine, spoke recently at a meeting of the Racine Diabetic Society. The regular monthly meetings, which draw about 100 persons and are open to the public, are sponsored by the Racine Optimist Club in cooperation with the Racine County Medical Society and St. Mary's Hospital.

Dr. Edward Saltzstein*

. . . director of the May and Sigmund Winter research laboratory at Mount Sinai Hospital in Milwaukee, was awarded an $11,200 research grant by the American Cancer Society effective July 1.

Doctor Saltzstein is a graduate of Northwestern University Medical School and is a clinical instructor in surgery at Marquette medical school.

The grant will be used for studies in an attempt to create a permanent tolerance of a grafted organ or tissue by a recipient animal.

Dr. Darold A. Treffert*

. . . superintendent of Winnebago State Hospital, addressed the Manitowoc County Medical Society May 1 in Manitowoc on the subject "The Drug Scene."

Dr. Paul L. Hartzler*

. . . Grantsburg, recently resigned from the medical staff at the Grantsburg Hospital and will join the Cambridge Clinic in Cambridge, Minn. Doctor Hartzler came to Grantsburg in 1965 from Ohio.

Dr. Kitti Kalambaheti*

. . . Sparta, resigned from the staff of the Sparta Clinic and has begun the practice of medicine in Osceola, Iowa. He is a native of Thailand and his specialty is surgery.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dr. Darrell S. Sharp*

. . . Mondovi physician for over 40 years, has retired from active practice. He and his wife will reside nine miles north of Cable near his boyhood home. An appreciation banquet was held in his honor May 29.

Dr. Richard F. Mattingly*

. . . professor and chairman of gynecology and obstetrics at Marquette medical school, has been named president-elect of the Milwaukee Gynecological Society. The incoming president is Dr. William J. Madden,* Racine. Dr. Samuel G. Perlson,* Milwaukee, was reelected secretary-treasurer.

Dr. Frank L. Weston*

. . . an emeritus professor of medicine, a teacher for 43 years, and an All-American end for the Badgers in 1920, received the 10th annual Emeritus Faculty Award from the Wisconsin Medical Alumni Association when it met in Madison in May. Doctor Weston continues his own practice as well as spending time teaching at the University. He has been treasurer of the State Medical Society for many years.

Dr. Robert E. Cullen*

. . . Fond du Lac, recently was appointed as associate member of the American College of Physicians.

Dr. K. H. Rusch to Help Reorganize State Mental Hygiene Division

Dr. Kenneth H. Rusch* has been named assistant administrator for management in the reorganization of the State Division of Mental Hygiene. He had been director of the division's community services section.

Dr. L. J. Ganser, administrator, who made the announcement June 4, said that in his new position Doctor Rusch will supervise the heads of four division units responsible for institution and community programs for the mentally ill, the mentally retarded, and alcoholics. He will assist the administrator on matters related to mental hygiene programs and practices.

Dr. Rusch

Doctor Rusch, a native of Manitowoc, graduated from the University of Illinois College of Medicine in 1948. His internship and residency training were taken at Queen's Hospital, Honolulu, Hawaii; University of Michigan, Ann Arbor; and Tripler Army Hospital. He practiced in Honolulu, served in the Army, returned to practice in Honolulu, and then came to Wisconsin in 1961 when he became associated with the Division of Mental Hygiene.

Midelfort Clinic Moves

Staff and associates of the Midelfort Clinic in Eau Claire moved in early June to new quarters across the street from Sacred Heart Hospital.

La Crosse County Heart Clinic

Dr. Robert M. Green,* La Crosse internist, examined a group of former rheumatic fever patients in June at a special consultative clinic sponsored by the Wisconsin Heart Association in cooperation with the La Crosse County Medical Society.

Dr. John Wear New President, Urologists

Dr. John B. Wear,* professor of urology, University of Wisconsin Medical School, Madison, has been elected president of the Wisconsin Urological Society for 1969 through 1970.

Dr. Robert J. Banker* of Manitowoc was elected president-elect. Dr. John D. Silbar* of Milwaukee was reelected secretary-treasurer.

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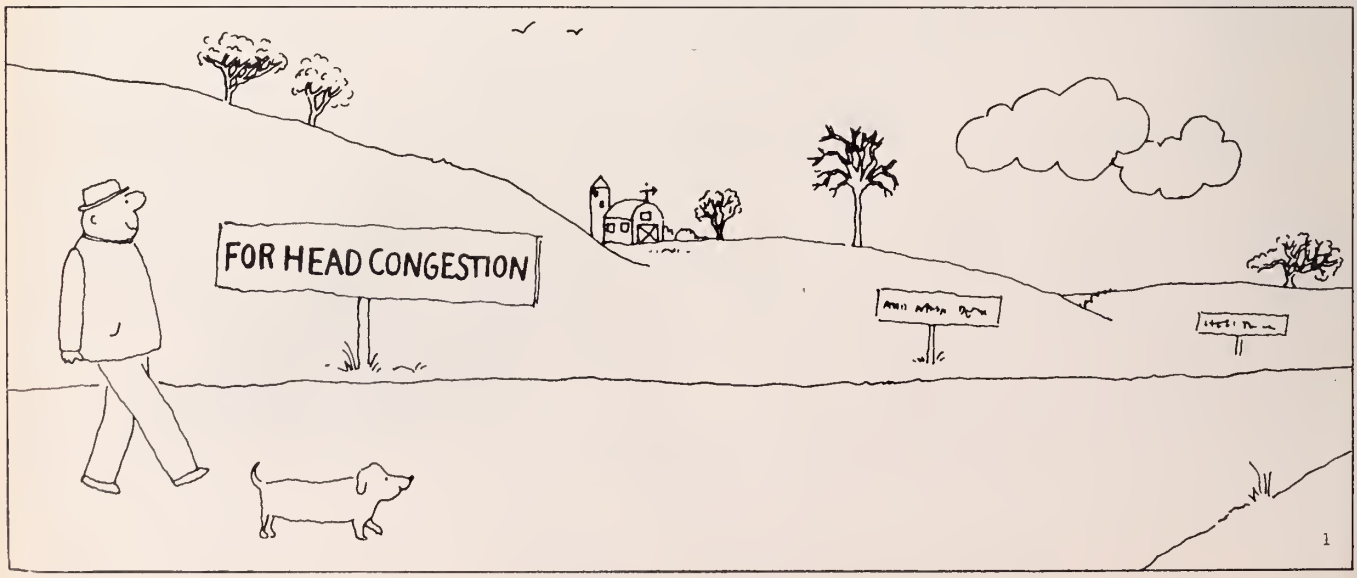


Dr. Lepley Heads Heart Association

Dr. Derward Lepley, Jr.,* Wisconsin's first heart transplant surgeon, was named president-elect of the Wisconsin Heart Association at its annual meeting June 7 in Milwaukee. Doctor Lepley will succeed Dr. George G. Rowe* of Madison as the president in June 1970.

Doctor Lepley is professor of surgery and chairman of the department of thoracic and cardiovascular surgery at Marquette School of Medicine and chief of cardiovascular surgery at St. Luke's Hospital in Milwaukee.

Dr. Lepley

Doctor Rowe, the new president, conducts cardiovascular research under a Research Career Development Grant from the U. S. Public Health Service and is a professor of medicine at the University of Wisconsin Medical Center.

Elected to the board of directors were Dr. Gerald W. Poindexter,* Milwaukee; Dr. John H. Morledge,* Roy T. Ragatz, and Dr. Robert W. Pohle, Madison; Dr. Louis J. Kurten,* Racine; and Dr. Richard D. Sautter,* Marshfield.

The outgoing president, Dr. Ross C. Kory,* professor of clinical research at Marquette, said Wisconsin residents had contributed almost $5 million to heart research in the past 20 years.

Dermatologist Joins Jackson Clinic, Madison

The Jackson Clinic in Madison has announced the association of a dermatologist, Dr. Hubert V. Moss, on their staff.

A graduate of the Medical College of Virginia, Dr. Moss is a Diplomate of the American Board of Dermatology and a Fellow of the American Academy of Dermatology. He will also serve as a clinical instructor of dermatology at the University of Wisconsin Medical School.

Dr. Moss

Prior to joining the clinic he was an Air Force dermatologist at Andrews A. F. B., Washington, D. C. He has recently been in private practice in Doctor's Park, Madison.

Dr. Stuart C. Cullen

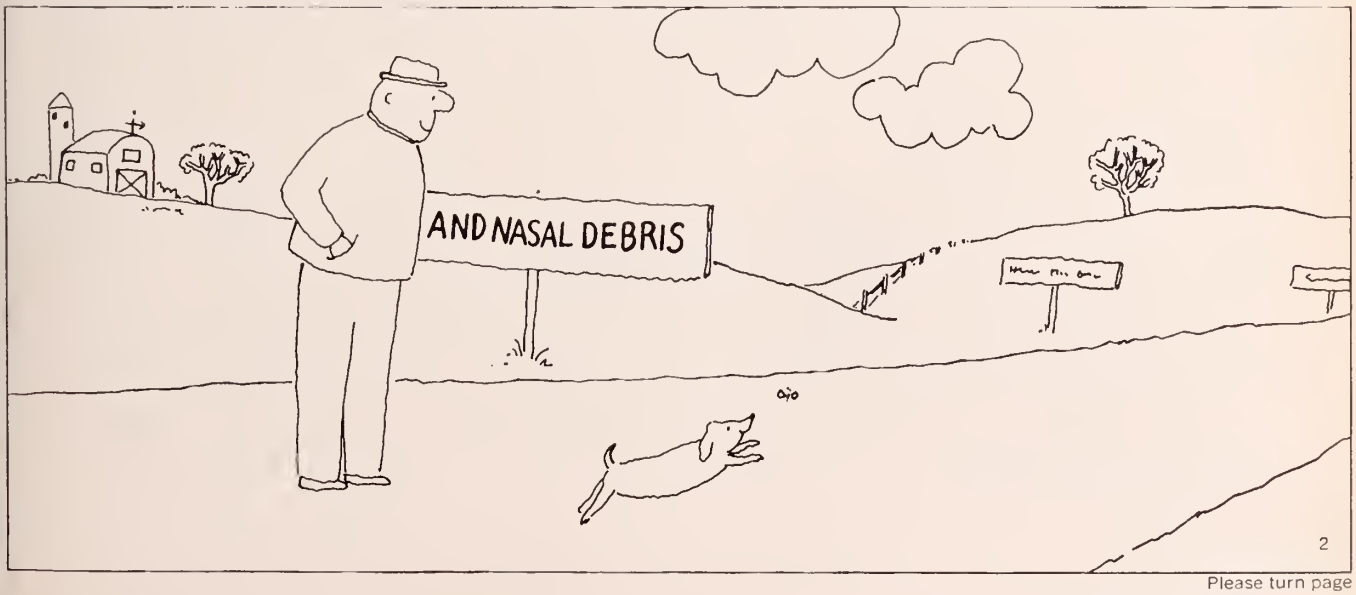
. . . a Wisconsin native who became dean of a California medical school, was the 12th recipient of the Wisconsin Medical Alumni Citation when the association met in May in Madison. Doctor Cullen, Belvedere, Calif., is dean of the University of California Medical School at San Francisco. He received the award for outstanding contributions to medical education. A 1933 graduate of the UW Medical School, he was on the University of Iowa Medical School faculty for 20 years before accepting the anesthesiology chairmanship at California in 1958. He became dean in 1966.

Drs. Henry E. Degroot*

. . . Racine; Richard E. Rieselbach and George T. Bryan,* Madison, were elected to fellowship in the American College of Physicians.

Dr. James Sargeant

. . . formerly of Mayville, recently joined the staff of the Lakeland Medical Associates in Minocqua. Doctor Sargeant graduated from Marquette University School of Medicine and served his internship at St. Joseph's Hospital, Milwaukee. He was associated with the Bachhuber Clinic in Mayville before going to Minocqua.



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Dr. Carl S. Harper*

. . . Madison physician and surgeon, recently was elected into Madison's Sports Hall of Fame. Doctor Harper earned all Western Conference recognition as a guard on Wisconsin's 1913 and 1914 basketball teams.

Dr. Vitoldas Balciunas*

. . . Kenosha, recently opened an office in Twin Lakes three days a week. He is on the staff of Kenosha and St. Catherine's hospitals in Kenosha. Doctor Balciunas studied in Zurich, Switzerland, and interned at Milwaukee Lutheran Hospital. He served a two-year residency at Columbus Hospital and a one-year residency at Cook County Hospital in Illinois.

Dr. Gene J. Pawlowski

. . . Milwaukee, now a captain in the United States Army, recently received the Army commendation medal. Doctor Pawlowski was recognized for his work in establishing and operating an eye clinic in Da Nang, South Vietnam.

Dr. John B. Wear, Jr.*

. . . Madison, recently won first prize for his exhibit, "The Diagnosis of Neurogenic Bladder," presented at the annual American Urological Association meeting in San Francisco.

Dr. Herman Shapiro's Equipment Given to Society Foundation

The complete furnishings and equipment of the late Dr. Herman Shapiro of Prairie du Chien have been given to the CES Foundation of the State Medical Society.

The equipment is being sent to Nicaragua to completely furnish a doctor's office in a rural area in that country. Nicaragua is a sister state of Wisconsin in the Alliance for Progress program.

Memorial money received from the many friends and patients of Doctor Shapiro, who died Dec. 30, 1968, also was given to the Foundation for use as a revolving Scholarship to help needy medical students finish their education.

In giving the money, Mrs. Shapiro said, "This was a good choice because Doctor Shapiro had always felt his education was never finished. There were too many new things in medicine all the time."

Dr. E. L. Belknap Honored

Marquette medical school's first distinguished service citation was presented to Dr. Elston L. Belknap* at commencement exercises June 1. This was the medical school's first graduation held independently from Marquette University.

Dr. Belknap is a professor emeritus and former chairman of occupational and environmental medicine. During his forty-year association with Marquette medical school, Dr. Belknap became known for his studies in the diagnosis and treatment of lead poisoning and was a leader in industrial medicine.

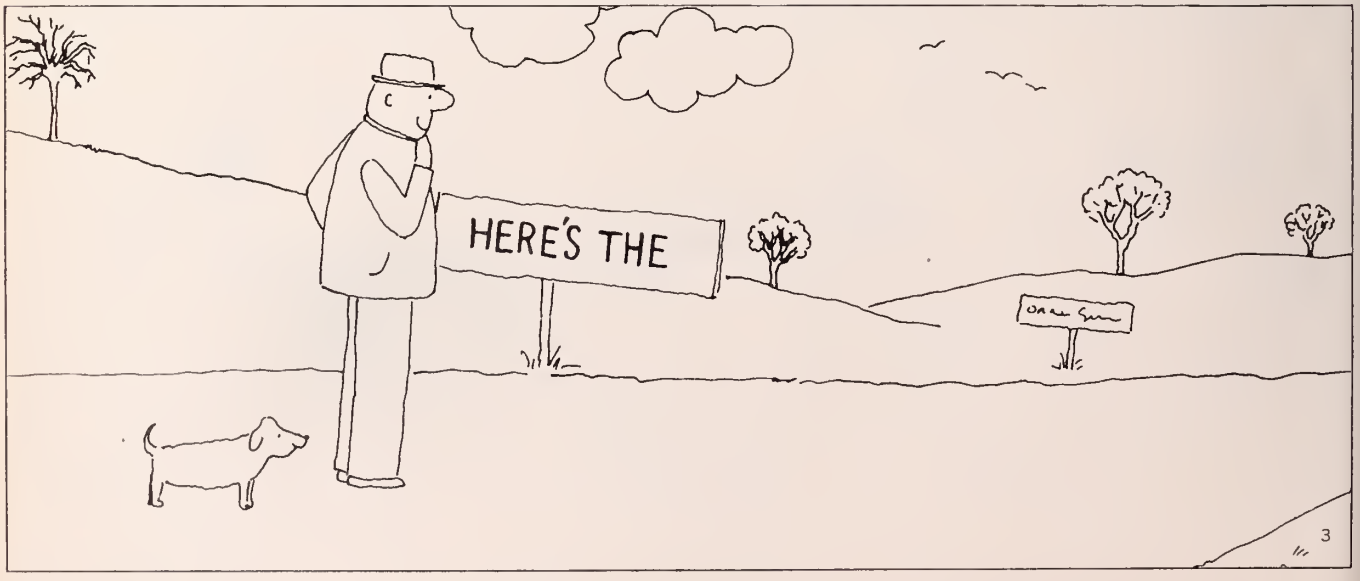
Dr. John Foley Heads Waukesha Society

In June the Waukesha County Medical Society elected new officers as follows:

President, Dr. John J. Foley,* Menomonee Falls; president-elect, Dr. G. Daniel Miller,* Oconomowoc; secretary, Dr. Martin Z. Fruchtman,* Waukesha; and treasurer, Dr. W. J. Kilbourn Clothier, Jr.,* Waukesha.

Columbus Hospital Closes Obstetrical Dept. May 31

The obstetrics department at St. Mary's Hospital in Columbus was closed May 31 until such time as qualified registered nurses can be hired to staff the department, according to Sister De Lellis Rayhert, hospital administrator.



Dr. Michael Rytel Joins Marquette

Dr. Michael W. Rytel has been appointed associate professor in medicine at Marquette School of Medicine, Milwaukee.

Doctor Rytel comes to the medical school from the University of Tennessee College of Medicine where he was on their faculty since 1966. From 1964–1966, he was a research fellow in virology at Cornell University Medical College. Doctor Rytel took his residency in internal medicine at Northwestern University Medical Center and Veterans Administration Research Hospital in Chicago, Ill. for the years 1960–61 and 1963–1964. He served in the U. S. Navy from 1961 to 1963 as an immunochemist in a research unit at Great Lakes naval base in Illinois.

Doctor Rytel received his MD degree from Northwestern University Medical School in 1958 and interned at Philadelphia General Hospital. His area of special interest is infectious diseases.

Dr. Jack Killins Elected Chrm., Commission on Scientific Medicine

A Green Bay surgeon, who has served on a number of medical society committees was elected chairman of the State Medical Society's Commission on Scientific Medicine by its members who met June 13 at Society headquarters in Madison.

He is Dr. Jack A. Killins* who is serving his final year of a five-year term on the Commission.

Prior to his Commission appointment, Doctor Killins was a member of the Society's Commission on Public Policy. While a member of this Commission he served as chairman of the Conference on Health Fads and Fallacies when it was held in Green Bay in 1965.

Dr. Killins

The past president of the Wisconsin Surgical Society, Doctor Killins also has served as president of the Brown County Medical Society.

He received his medical training at the University of Nebraska College of Medicine graduating in 1937, interned at Charles T. Miller Hospital in St. Paul, Minn.; and served his surgical residency at the Mayo Clinic in Rochester, Minn.

Following military service in the Army Medical Corps, Doctor Killins returned to the Mayo Clinic as first assistant in surgery. He joined the Green Bay Clinic in 1946 and has been certified by the American Board of Surgery.

Dr. Darius K. Shahrokh*

. . . Fond du Lac, recently examined students for possible hearing problems in the State Otomobile which is sponsored by the Bureau for Handicapped Children of the State Department of Public Instruction.

Dr. Donald Vangor*

. . . Wisconsin Dells, recently resigned from the staff at the Dells Clinic and has become associated with the Baraboo Medical Building in Baraboo.

Dr. Herbert R. Lazarus

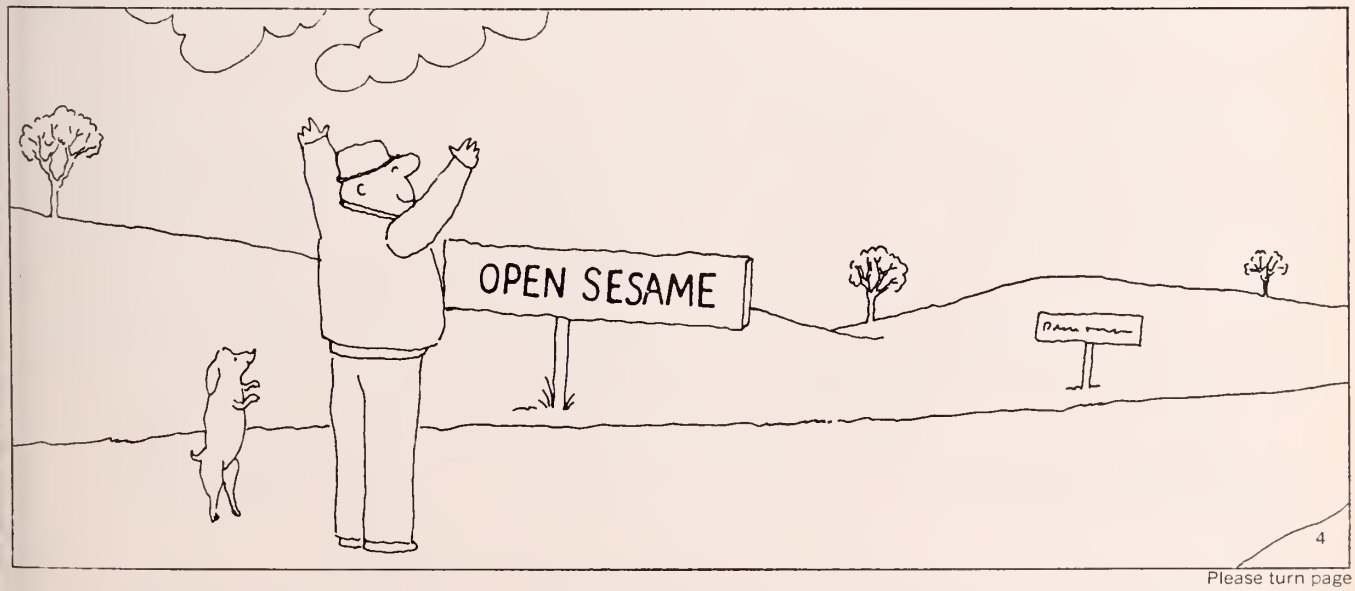
. . . psychiatrist-director of the Washington County Guidance Center since 1966, recently resigned his position and moved to Tucson, Ariz. Dr. Richard P. Gerhardstein,* who has been a staff psychiatrist at the center since February, took over the position with the title of "acting psychiatrist-director."

Dr. Donald A. Miller*

. . . Gillett, has been elected to active membership in the American Academy of General Practice.

Dr. Frank N. Dukerschein*

. . . Oregon physician for the past 18 years, recently moved to Berlin to become associated with the Seward Clinic. Doctor Dukerschein was born in Berlin and spent his early youth there.



Please turn page

Drs. E. C. Eickhoff*

. . . Land O' Lakes, and R. R. Wolcott,* Phelps, are two of the physicians that staff the new Northwoods Clinic in Phelps. A dedication program and open house was held recently for the new clinic and extended hospital facilities at the Northwoods Hospital.

Dr. Stephen C. Copps*

. . . La Crosse, has been appointed to the National Examination Committee of the American Academy of Pediatrics. He is one of 30 pediatricians throughout the country who are members of the Academy's evaluation committee.

Dr. William C. Curtis*

. . . Elm Grove, was appointed chief of the medical staff of the new Elmbrook Memorial Hospital in Brookfield. Doctor Curtis had been chief-of-staff at Misericordia Hospital which recently closed. Other members of the staff are: Drs. John T. Hotter,* vice chief-of-staff; T. C. Puchner,* Milwaukee, secretary-treasurer; H. F. Twelmeyer,* Wauwatosa, surgery; W. G. Longe,* Elm Grove, medicine; R. S. Pavlic,* Brookfield, obstetrics–gynecology; Donald L. Wood,* Elm Grove, general practice; and F. L. Ziehl,* Brookfield, in-hospital services.

Dr. Johnson New Chief of Staff, UW Hospitals

Dr. Robert O. Johnson* was installed June 23 as the new chief-of-staff at University of Wisconsin Hospitals. He succeeds Dr. Benjamin Glover* of the psychiatry department in the two-year term.

Doctor Johnson is associate professor of surgery and subspecializes in general surgery. He received his MD degree at the University of Wisconsin, interned at Philadelphia General Hospital, and served his residency in surgery at the UW Hospitals. Doctor Johnson spent seven years in general practice and the last six years at the UW Medical Center.

Dr. Johnson

Installed with Doctor Johnson was Dr. Edgar S. Gordon* as vice chief-of-staff. Doctor Gordon is professor of medicine with a subspecialty in endocrinology. He succeeds Doctor Johnson as vice-chief. Dr. Raymond W. M. Chun* was installed as secretary-treasurer. He is associate professor of neurology and pediatrics and succeeds Dr. Jack J. Chosy, assistant professor in psychosomatic medicine.

Dr. Mueller, Appleton, Heads Fox Valley Group

Dr. Gilbert Mueller,* Appleton, was reelected president of the Fox Valley Academy of Medicine at its meeting June 2 in the Kimberly–Clark Marketing Center, Neenah.

Doctor Mueller presented the board of directors for 1969–70 as follows: Drs. Donald Bravick,* James Erchul,* Thomas Loescher,* and John Mielke,* Appleton; Drs. Timothy Flaherty,* Palu Gohdes,* Malcolm McCutcheon,* and Douglas Reilly,* Neenah; and Dr. William Crawford,* Oshkosh.

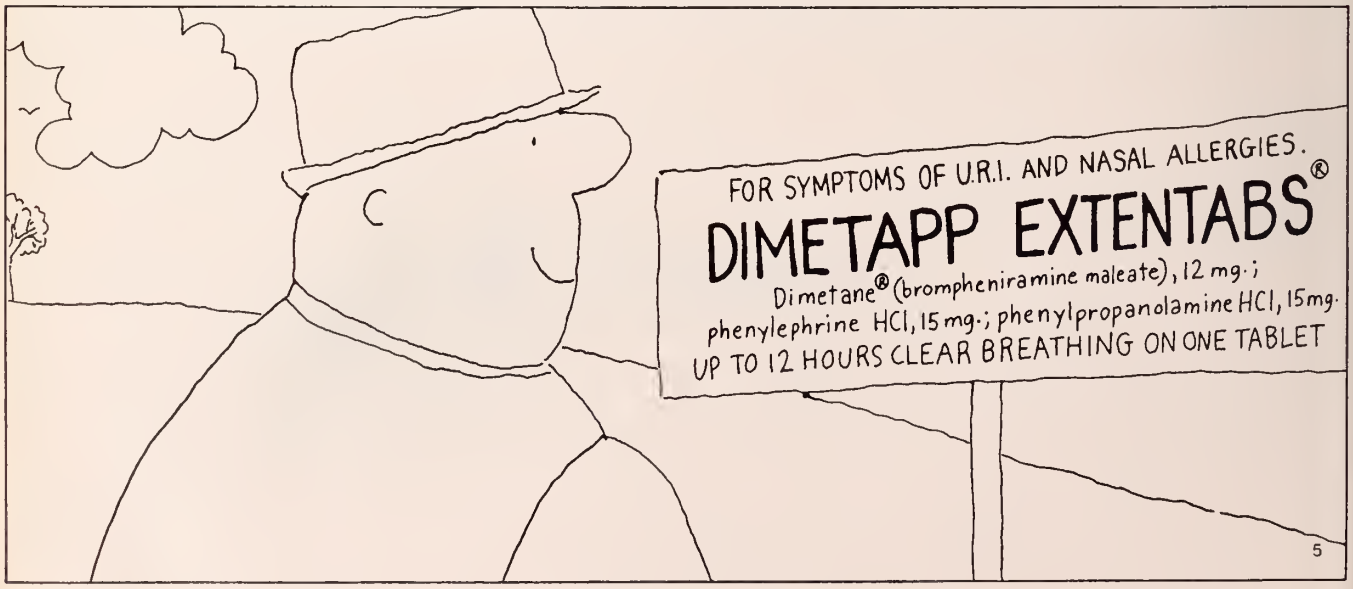
About 75 members of the Academy heard Dr. Louis Tobian, professor of the University of Minnesota Medical School, talk on "When and How to Treat the Patient with Hypertension."

Also at the meeting, Dr. Arthur C. Taylor,* Appleton, presented to the Academy a gavel fashioned from satinwood which was brought back from Ceylon by Doctor Mueller after serving on the SS HOPE hospital ship.

Member physicians are from a four-county area: Calumet, Outagamie, Waupaca, and Winnebago.

Krohn Clinic Has Open House

A grand opening and public inspection of the new Krohn Clinic at Black River Falls was held Sunday, June 15.



Two Radiologists Join Marquette

Drs. Frank E. Maddison and Wylie J. Dodds have been appointed to the Division of Radiology at Marquette School of Medicine, Milwaukee.

Their appointments are part of a faculty expansion program begun over a year ago when Dr. James E. Youker, formerly of the University of California School of Medicine in San Francisco, became professor and chairman of radiology. Through Doctor Youker's efforts Milwaukee County General Hospital has gained approval of its physician training program in radiology which was lost three years ago for lack of teaching staff. The medical school has appointed eight radiologists to its teaching staff within the past year.

Doctor Maddison, associate professor in radiology, had been on the faculty at the University of California School of Medicine, San Francisco, since 1961. His area of specialization is vascular radiology.

Before joining the Marquette staff, Doctor Dodds, assistant professor in radiology, had been a research fellow for the United States Public Health Service at Stanford University Hospital. In 1968, he was appointed a clinical instructor at the University of California School of Medicine in San Francisco, where he had taken his residency training in radiology. His area of specialization is gastrointestinal radiology.

Gundersen Clinic to Have IM Residency Program

A residency training program in internal medicine has been approved for the Gundersen Clinic, Ltd. Lutheran Hospital in La Crosse, according to an announcement by Dr. Edwin L. Overholt,* director of medical education and research at the clinic.

Approved is a three-year training program to start in July 1970. Three physicians will enter the program at each year's level—a total of nine physicians. It is one of nine internal medicine residency programs in Wisconsin and is one of two residencies not under the direction of the medical schools at the University of Wisconsin or Marquette.

The program was approved by the American Board of Internal Medicine, American College of Physicians, and the Council on Medical Education of the American Medical Association.

The clinic presently has one-year programs in surgery and pediatrics.

The clinic's educational program is sponsored by the Adolf Gundersen Medical Foundation and the La Crosse Lutheran Hospital.

Dr. Thomas E. Dugan*

. . . Waukesha, recently was elected president of the medical staff of Waukesha Memorial Hospital. He succeeds Dr. James V. Bolger, Jr.,* who resigned. The staff also elected Dr. Earl G. Schulz* as vice-president and Dr. Aaron Sweed* as chief-of-medical-staff.

Dr. Thomas M. Zurkowski

. . . formerly of Baltimore, Md., recently became associated with the Medical Associates of Beloit. Doctor Zurkowski graduated from Creighton University School of Medicine, Omaha, and recently served as a member of the staff of the US Public Health Service Hospital in Baltimore.

Dr. Arnold H. Barr*

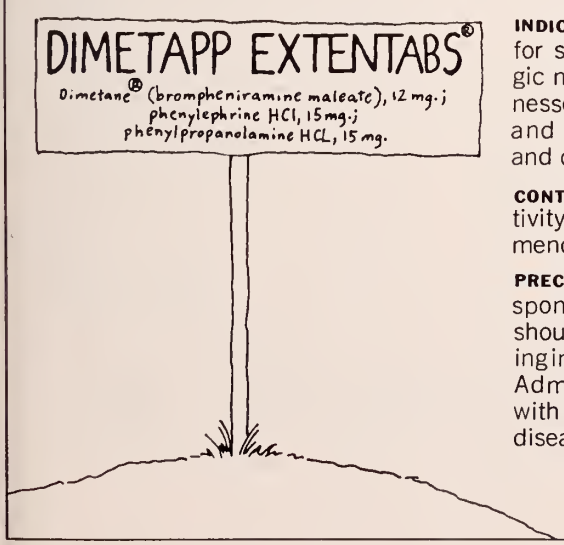
. . . Port Washington, recently was reelected to a four-year term on the board of directors of Wisconsin Blue Cross.

Dr. Roy B. Larsen*

. . . Wausau surgeon, recently was elected president of the Wausau police and fire commission.

Dr. James L. Rice

. . . a native of Marshfield, in June completed a three-year residency in psychiatry at the Menninger School of Psychiatry, Topeka, Kan.



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CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

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6

GOVERNOR WARREN P. KNOWLES views an "MDs Like It Here" flag created by Mrs. Theodore Hegley of Baraboo and Dr. W. D. James of Oconomowoc, immediate past president of the State Medical Society. Opportunity for the unveiling came on May 22 when Doctor James presented Governor Knowles with an "MDs Like It Here" lapel pin similar to the one Governor Knowles made famous. The Society has launched a six-point program to ease the "doctor drain" in Wisconsin and to "provide even better health care for all our citizens." The gold and black lapel pin, shaped like the state itself, is being distributed to all Wisconsin physicians, their wives, and other members of the health team. The gold and black flag, sewn on white satin, took 95 hours to make, according to Mrs. Hegley, who is the daughter of C. H. Crownhart, secretary of the State Medical Society. The flag, a close resemblance to the lapel pin, hangs in the Society headquarters in Madison.

Madison to Host First Training Course on Emergency Aid for Ill and Injured

The first training course on emergency aid and transportation of ill and injured persons to be held in Madison, under sponsorship of the Committee on Injuries of the American Academy of Orthopaedic Surgeons and the University of Wisconsin is scheduled Aug. 21–23 at the Wisconsin Center, 702 Langdon Street.

Invited to attend the three-day course of lectures and demonstrations are ambulance attendants, nurses, policemen, firemen, safety engineers, volunteer rescue squads, and others responsible for dealing with members of the public ill or hurt in accidents.

The advanced training meeting is to be given in cooperation with the State Medical Society of Wisconsin, Wisconsin Chapter of the Committee on Trauma, American College of Surgeons, and other organizations.

The death rate from accidental injuries can be reduced by improved training of emergency personnel, according to Dr. Kenneth M. Sachtjen,* Madison orthopaedic surgeon, who has organized the program and will direct the course.

"A fast ride by ambulance or other means has practically never saved a life," he said. "There is often only a few minutes to reestablish heart action and breathing, time too short for even a 90-mile-an-hour trip to the hospital for treatment."

"What is really needed is an emergency crew well schooled in preparing the injured for transport. This means being able to make a quick survey, to determine medical priority, and take the necessary life-saving measures."

To furnish this instruction, faculty members of the University of Wisconsin Medical School, members of the Dane County Medical Society, and others will speak and cooperate in the demonstration of a wide range of subjects, including resuscitation, cardiac massage, splinting of fractures, burns, and other medical emergencies.

Aid to water accident victims, handling the mentally disturbed, rescue from electricity, extrication from crushed or overturned vehicles, emergency childbirth, and even the legal aspects of first aid will be covered.

The comprehensive course is one of a series being conducted in major cities by the Academy's Committee on Injuries, whose chairman is Dr. George E. Spencer, Jr., Cleveland orthopaedic surgeon. Cities include New Orleans, Boston, New York, San Diego, Miami, and Portland, Ore.

For information and registration forms, those interested may write to Coordinator, Emergency Care Conference, Wisconsin Center, 702 Langdon Street, Madison, Wis. 53706.

Police, Fire Surgeons Organize Nationally

The State Medical Society has been notified of the formation of an ad-hoc committee whose purpose is to establish a national society of Police and Fire surgeons. Physicians interested in becoming participating members of this society are invited to contact Howard Schneider, MD, 75 Lee Avenue, Yonkers, N. Y. 10705.

Members of the ad-hoc committee are: Howard Schneider, MD, chairman, Police Surgeon, Westchester County; Charles Marrone, MD, vice-chairman, Fire Surgeon, Yonkers, N. Y.; Date Catullo, MD, Police Surgeon, Yonkers, N. Y.; George Sonnenberg, MD, Police Surgeon, New York State; Chief Andrew Gerlock, Fire Advisory; Chief Marvin Erickson and Inspector Nicholas Maniscalco, Police Advisory; Hon. Albert Fiorillo, Legal Counsel; Ben Binstock, Insurance Advisory; and Clarence Duryea, Hospital Advisory.

CONTRIBUTIONS—CES FOUNDATION

May 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for May 1969:

Nonrestricted

Sheboygan County Medical Society Auxiliary
State Medical Society — Voluntary contributions of 126 MDs
Dr. and Mrs. C. F. Broderick — Memorial: Edward P. Fitzgerald
David N. Goldstein, MD — Memorial: Mrs. Rose Aiello
Dr. and Mrs. Leonard Schrank — Memorial: Mrs. Glenn Mugridge
Dr. and Mrs. Leonard Schrank — Memorial: Mrs. Harry Beyers
E. J. Nordby, MD — Memorial: C. W. Aageson, MD
Leslie G. Kindschi, MD — Memorial: C. W. Aageson, MD
State Medical Society — Memorial: Allen G. Johnson, MD
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Woman's Auxiliary to La Crosse County Medical Society — In Honor of: Mrs. James Sargent

Museum of Medical Progress

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History of Nursing in Wisconsin Exhibit

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UW Interns, Residents Honored

Physicians who had completed internships and residency requirements at the University of Wisconsin Hospitals were honored in ceremonies in early June.

Certificates were presented to 40 interns and 70 residents.

Two residents were presented outstanding teaching awards. They are Dr. Francisco Jaramillo, a resident in urology; and Dr. Frank L. Wolf, a resident in surgery.

The teaching awards are voted annually by the senior class.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JUNE 1969

1 **Marquette Medical School Graduates Reception–Luncheon (Milwaukee)**
2 Dane County Medical Society Insurance Advisory Committee
3 State Pharmacy Board Examination
3 Dane County Medical Society Board of Trustees, Madison Anesthesiology Society, Madison General Hospital Surgical Staff, and Madison Urological Society Annual Steak Cookout
6 Madison Society of Obstetrics and Gynecology
7 SMS Commission on Medical Care Plans
9 University of Wisconsin Medical School Graduates Reception–Luncheon
11 Inter-Organization Committee, Wisconsin Nurses Association and Wisconsin League of Nurses
12 SMS Commission on Public Policy
13 SMS Commission on Scientific Medicine
15 President's Reception: Dr. Robert E. Callan
21 AMA Delegates Caucus (Milwaukee)
26 Health Planning Council, Inc.
26 Conference on Planning for AMA 1970 Rural Health Council (Madison)
28 Executive Committee, SMS Council
28 Executive Committee, SMS Commission on Medical Care Plans

Meetings not held in the Society "Home" but which have o direct relationship are printed in bold face with the locotion in parentheses.

DR. ROBERT G. ZACH'S* MEDICAL JEWELRY helped obtain another doctor for The Monroe Clinic in Monroe. He is Dr. Mehboobmian Mustafamian Qureshi, a native of Ahmedabad, India. Dr. "Meb" Qureshi, whose family trace ancestry to the Prophet Mohammed, is in the internal medicine department with a specialty of pulmonary diseases. It all began when Doctor Qureshi's wife cut an advertisement out of a medical publication regarding the unusual jewelry made and sold by Doctor Zach; it was filed for a Christmas suggestion; and then when the inquiry came to Doctor Zach, he presumed (mistakenly) that his new customer was a resident-in-training in a chest hospital in Wilmington, Del. He was looking for such a physician and sent some information on the Clinic with the order. Coincidentally the Qureshis were thinking about locating in such an environment as Monroe. Several months later, in April, the Qureshis were settled in Monroe. (Photo courtesy MONROE EVENING TIMES)

Residency, Student Training Program At Marshfield

An expanded, affiliated residency and student training program in internal medicine was formally launched July 1 at St. Joseph's Hospital in Marshfield.

Dr. George Magnin,* a member of the department of internal medicine at the Marshfield Clinic since 1952, will head the program which will be totally directed and run by the University of Wisconsin Medical School.

Dr. Magnin has been named associate professor of medicine at the UW Medical School. He has been relieved from active practice at the Clinic in order to assume full-time duties at the hospital to direct the entire program.

The UW will maintain one resident, one intern, and two medical students at the hospital on a full-time basis to staff this internal medicine program.

The Marshfield Clinic and St. Joseph's Hospital participate in the UW preceptorship program with senior medical students and they also participate in other residency programs with the UW.

Employers Ins. Wins Safety Film Award

Dr. O. Tod Mallery, Jr.,* medical director of Employers Insurance of Wausau, recently presented a print of the 28-minute documentary, "Before the Emergency," to Dr. Charles V. Heck, director of the American Academy of Orthopaedic Surgeons.

Produced by Employers Insurance and recently awarded highest honors as "Safety Film of the Year" by the National Committee on Films for Safety, "Before the Emergency" tells the story of inadequate care and treatment of accident victims due to the unpreparedness of many American communities.

Lack of proper equipment in ambulances, lack of thorough education and training for crews, and lack of radio communication between ambulances and hospitals are cited as principal reasons for the unnecessary death of an estimated 20,000 accident victims each year and the permanent disability of approximately 25,000 more.

Most startling of the information revealed is the fact that only 6 of the 50 states have subscribed to the minimum ambulance equipment regulations of the American College of Surgeons (which has endorsed "Before the Emergency"), only 13 states regulate ambulance operations, and just 18 states regulate personnel. Further, only one-fourth of all ambulance attendants in the U.S. have received any education in first aid. In many states a beautician is required by law to have acceptably completed more hours of training than those who attend to the injured victims of accidents.

"Before the Emergency" also details a program of recommended community action such as that adopted in Wisconsin by the resort city of Minocqua under the guidance of Dr. J. D. Farrington,* who appears in the film.

Employers donated prints of the color film to the Academy for use in its library and in training on "Emergency Care and Transportation of the Sick and Injured." Courses on the subject, sponsored by the American Academy of Orthopaedic Surgeons, will be conducted in 18 locations throughout the country in 1969.

A booklet on the subject of emergency care will be sent free to anyone who writes Employers Insurance of Wausau, Wausau, Wis. 54401. Color prints of "Before the Emergency" are available on loan to interested organizations that contact Modern Talking Pictures Corp., 1909 Prudential Plaza, Chicago, Ill. 60601. □

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MAY 23, 1969

NEW MEMBERS

Baker, Robert M., 2462 Fontaine Circle, Madison 53713
Blank, Richard J., 2464 Fontaine Circle, Madison 53713
Cook, Colin B., 4923 W. National Ave., Milwaukee 53214
Cyrus, Andrew E., Jr., 561 N. 15th St., Milwaukee 53233
Douglas, Herbert J., Box 7274, Milwaukee 53213
Farkas, Mary Elizabeth, 927 South 8th St., Manitowoc 54220
Fernandez, Pascual B., 1717 W. Greenfield Ave., Milwaukee 53204
Flemma, Robert John, 8700 W. Wisconsin Ave., Milwaukee 53226
Galang, Miguel T., Jr., 9008 W. Burleigh, Milwaukee 53222
Gerhardstein, Richard P., 8844 Watertown Plank Rd., Milwaukee 53226
Gosset, Franz R., 3810 Euclid Ave., Madison 53711
Huizenga, Bernard A., 10514 W. Rae Ave., Milwaukee 53225
Janusonis, Palmira A., 3515 North 54th St., Milwaukee 53216
Khoja, Sherali, 114 Seventh St., Racine 53403
Kindwall, Eric Post, 2900 W. Oklahoma Ave., Milwaukee 53215
Kuwayama, Susumu Paul, 1570 N. Prospect Ave., #910, Milwaukee 53202
Lescher, Hazel Norma, 8901 W. Lincoln Ave., Milwaukee 53227
Lubar, Howard S., 20 South Park St., Madison 53715
Madsen, Paul O., 2500 Overlook Terr., Madison 53705
Manning, Timothy A., 2645 Chatsworth Dr., Beloit 53511
Mansell, Frederick T., 325 Butts Ave., Tomah 54660
Matsis, John Peter, 5000 W. Chambers St., Milwaukee 53210
Miller, James D., 950 College Ave., Stevens Point 54481
O'Brien, Marilyn J., 5900 S. Lake Dr., Cudahy 53110
O'Malley, Thomas P., 2501 Main St., Stevens Point 54481
Ortwein, Robert K., 5625 Washington Ave., Racine 53406
Ouellette, John J., 1300 University Ave., Madison 53706
Parnell, Diana D., 2429 Allied Dr., Madison 53711
Pier, Philip E., 580 N. 105th St., Milwaukee 53226
Pohlmann, Guenther Peter, 3321 N. Maryland Ave., Milwaukee 53211
Rabor, Antonio A., Jr., 5900 S. Lake Dr., Cudahy 53110
Salvador, Fernando E., 2031 Riverside Dr., Beloit 53511
Scerpella, Jaime R., 926 Milwaukee Ave., South Milwaukee 53172
Shanberge, Jacob N., Mt. Sinai Hospital, Milwaukee 53233
Small, James Thomas, Jr., 8700 W. Wisconsin, Milwaukee 53226
Vandervort, Glenn E., 301 Troy Dr., Madison 53704
Wahl, Joseph W., 1836 South Ave., La Crosse 54601

REINSTATED

Christopher, Chris C., Sr., 950 North 35th St., Milwaukee 53208

CHANGES OF ADDRESS

Brousseau, Edward R., P. O. Box 224, Eau Claire 54701
Brown, Roland C., Milwaukee, to 2554 N. 100th St., Wauwatosa 53226
Cainton, Gerald L., 2727 Marshall Court, Madison 53705
Carey, Larry C., Elm Grove, to Dept. of Surgery, Presbyterian University Hospital, Pittsburgh, Pa. 15213
Cassidy, George E., Brookfield, to 1716 N. 68th St., Wauwatosa 53213
Damp, Orville E., Birnamwood, to King 54946
Edson, Jack D., Wales, to P. O. Box 224, Eau Claire 54701
Eisenberg, Louis A., Bal Harbour, Fla., to 1610 N. Prospect Ave., Milwaukee 53202
Fine, Robert A., P. O. Box 342, Milwaukee 53201
Flynn, Richard T., Jr., Route 2, P. O. Box 419, East Troy 53120
Halgrimson, Kenneth, P. O. Box 224, Eau Claire 54701
Hanley, Larry L., Whitehall, to Krohn Clinic, Black River Falls 54615
Hassler, Robert E., Route 2, Monroe 53566
Hodges, Paul C., Jr., 612 E. Longview Dr., Appleton 54911
Karrmann, Paul L., 601 Reed Ave., Manitowoc 54220
Lavine, Daniel M., P. O. Box 342, Milwaukee 53201
Lorenz, A. A., P. O. Box 224, Eau Claire 54701
Mathison, Johan A., Milwaukee, to 2121 Bowen St., Oshkosh 54901
Natenshon, A. L., 208 East Wisconsin Ave., Milwaukee 53202
Niver, Edwin O., P. O. Box 224, Eau Claire 54701
Novotny, Clarence G., 1551 Dousman St., Green Bay 54303
Rifleman, R. H., 1368 College Ave., Stevens Point 54481
Slette, Darrell R., 612 E. Longview Ave., Appleton 54911
Slotnik, Irvin L., 5255 N. Mohawk Ave., Milwaukee 53217
Sprague, L. V., 1912 Atwood Ave., Madison 53704
Tobin, Joseph M., P. O. Box 224, Eau Claire 54701
Truszkowski, A. J., Bethesda, Md., to A.P.O., San Francisco, Calif.
Weeks, James H., Monroe, to Guthrie Clinic Ltd., South Wilbur Ave., Sayre, Pa. 18840
Weihe, Arthur R., Adams, to Friendship 53934
Zahl, Wesley H., Burbank, Calif., to 6166 S. Packard Ave., Cudahy 53110
Zizic, Thomas M., San Antonio, Tex., to 127 Thornell, Brooks A. F. B., Tex. 78235

REMOVED FROM MEMBERSHIP

Aug, Robert G., Milwaukee County, transferred to Kentucky
Bentley, John D., Dane County, transferred to Missouri
Casey, Peter N., Milwaukee County, resigned
Hutchens, Jerome E., Milwaukee County
Keller, Meredith E., Winnebago County, transferred to Illinois
Schultz, James H., Washington County, resigned

DEATHS

Johnson, Allen G., Oneida–Vilas County, Apr. 3, 1969
Mack, Robert F., Wood County, Apr. 15, 1969
Pollock, Frederick, nonmember, Apr. 22, 1969
Beebe, George W., Eau Claire–Dunn–Pepin County, Apr. 24, 1969 □

Squibb Film: "The New Generation"

E. R. Squibb & Sons, Inc. announced recently the completion of a unique documentary film entitled, "The New Generation," a film that stresses the positive and constructive aspects of our youth as seen through the lives of a young American couple. The 28-minute feature was premiered at the 118th Convention of the American Medical Association in New York City July 13–18. It is now available to any physician who wishes to obtain it, for group viewing in his local area.

A recently married couple, in their early twenties, was selected to tell the story of their generation. Both have strong feelings about society and its needed changes. They are out to win a world to their liking through constructive action rather than through riots or violent demonstrations. They will achieve their goals simply by being what they are—for they represent "The New Generation"—the leaders of tomorrow. □

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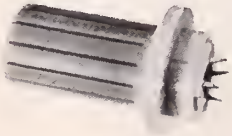

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OBITUARIES

Dr. Traugott H. Nammacher, 69, Oconomowoc physician for over 38 years, died May 10, 1969, in Oconomowoc.

Born Jan. 1, 1900, in Sleepy Eye, Minn., Doctor Nammacher received his B.A. and M.A. degrees from the University of Wisconsin and graduated from Rush Medical College, Chicago, in 1930. He took his internship at Lutheran Deaconness Hospital, Chicago, and also did postgraduate work at the Polyclinic Hospital, New York City. He was a charter member and an area officer of the Wisconsin Chapter of the American Academy of General Practice and was chairman of the medical committee on the board of Lutheran Homes, Inc.

Doctor Nammacher was a past president of the Waukesha County Medical Society, a member of the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Rose; three sons, Thomas, Minneapolis; Frederick, Seattle; and Dr. Mark, Guatemala; and one daughter, Emily, New York City.

Dr. Carl W. Aageson, 64, prominent Madison ophthalmologist, died May 15, 1969, in Madison.

He was born Nov. 19, 1904, in Britt, Iowa, and graduated from the State University of Iowa Medical College in 1930. His internship was taken at Madison General Hospital. Doctor Aageson was certified by the American Board of Ophthalmology and was a member of the American Academy of Ophthalmology and Otolaryngology.

He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Alma; and two daughters, Mrs. Ann Kimbrough, Denver, Colo., and Mrs. W. L. Brink, Memphis, Tenn. □

Booklet: Survey of Hospital Charges

The Health Insurance Council has announced publication of "Survey of Hospital Charges as of December 1968," an itemized breakdown of hospital expenses throughout the nation.

The book details costs—including x-ray, drug and laboratory—in terms of average hospital charges. It divides the United States into census division, state, and standard metropolitan statistical areas including the nation's 25 largest counties.

The national survey also reports on charges for intensive care and extended care units as well as average daily service charges in both voluntary and proprietary hospitals.

It was prepared by the American Hospital Association for the Council.

To obtain a copy, write to William W. Reinertson, Health Insurance Council, 750 Third Avenue, New York, N. Y. 10017.

Price is $10.00 for the first copy and $5.00 for each additional copy. □

Films: Human Anatomy and Cancer Management

Two series of 16mm teaching films on human anatomy and on current concepts and practices for cancer management have been produced by The American College of Radiology, according to Dr. Ted F. Leigh of Atlanta, chairman of the College Committee on Audio-Visual Media.

The normal anatomy films and the cancer management films may be borrowed from the American Medical Association film library, 535 North Dearborn Street in Chicago, or from the National Medical Audio Visual Center of the U. S. Public Health Service, Atlanta, Ga. □

the wisconsin medical journal

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COUNTY MEDICAL SOCIETIES

Presidents and secretaries of the 54 component county medical societies are listed periodically.

MEDICAL MEETINGS
POSTGRADUATE COURSES

1969 WISCONSIN

Sept. 4: Postgraduate course—The Dentist and Cancer Control, University of Wisconsin Medical Center, Madison.

Sept. 11–14: Annual Meeting, Wisconsin Society of Internal Medicine, Kaehlers Resort (formerly Uphoffs') Lake Delton (changed from Deer Park Lodge).

Sept. 14–16: Wisconsin Pharmaceutical Association 89th annual convention, Wisconsin Dells.

Sept. 19–20: Annual meeting, Wisconsin Orthopaedic Society, Dellview Hotel, Lake Delton.

Sept. 19–21: Twentieth annual meeting, Wisconsin Radiological Society, The Abbey, Fontana.

Sept. 19–21: Annual meeting, Wisconsin Society of Anesthesiologists, The Abbey, Fontana.

Sept. 20: Annual meeting, Wisconsin Society of Obstetrics and Gynecology, Bailey's Harbor, Door County.

Sept. 25: Thirty-ninth Annual Marquette–Jackson Clinic Postgraduate Meeting, Park Motor Inn, Madison.

Sept. 26–28: Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Dell View Hotel, Lake Delton.

Sept. 27: Fifteenth annual fall cancer conference (Cancer Scrimmage—Wis. vs. UCLA), University of Wisconsin Medical Center, Madison.

Oct. 1: 4th annual Symposium of Adolf Gundersen Medical Foundation and Wisconsin Heart Association entitled "Acute Myocardial Infarction," La Crosse.

Oct. 3: Fall Pediatric Day, Wisconsin Academy of Pediatrics and University of Wisconsin Department of Pediatrics, Wisconsin Center, Madison.

Oct. 3–4: Annual meeting, Easter Seal Society of Wisconsin, Beaumont Motor Inn, Green Bay.

Oct. 6–10: Wisconsin Work Week of Health, State Medical Society, to be held each day in a different city: Eau Claire, Wausau, Green Bay, Milwaukee, and Madison.

Oct. 8–9: Annual meeting, Wisconsin Academy of General Practice, Holiday Inn No. 2, Madison.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton–Schroeder Hotel, Milwaukee.

Nov. 22: Fall meeting, Wisconsin Society of Pathologists, St. Mary's Hospital, Madison.

1969 NEIGHBORING STATES

Sept. 14–20: College of American Pathologists, Chicago, Ill.

Sept. 14–21: American Society of Clinical Pathologists, Chicago, Ill.

Sept. 15–16: Biennial meeting of State Medical Journal Advertising Bureau, Chicago, Ill.

Sept. 18–19: Course on Venous and Lymph Disorders of the Lower Extremity, Mayo Clinic and Mayo Foundation, Rochester, Minn.

Sept. 19–20: Conference on Stroke, American Rehabilitation Foundation, Minneapolis, Minn.

Sept. 19–20: Cardiovascular Symposium, Iowa Heart Association in cooperation with the Great Plains Heart Associations, University of Iowa Health Center, Iowa City.

Sept. 22–23: Midwest Interprofessional Seminar on Diseases Common to Animals and Man, Memorial Union, Iowa State University, Ames.

Sept. 25–27: Workshop on Clinical Hypnosis and Hypnotherapy, American Society of Clinical Hypnosis-Education and Research Foundation with the Department of Neurology and Psychiatry of the University of Minnesota, Minneapolis.

Oct. 3–4: Conference on Urology, University of Iowa, Iowa City.

Oct. 4–10: Annual Otolaryngologic Assembly of 1969, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Oct. 10–11: American Society of Ophthalmologic and Otorhinolaryngologic Allergy, Chicago, Ill.

Oct. 11–12: American Association of Ophthalmology, Chicago, Ill.

Oct. 12–17: American Academy of Ophthalmology and Otolaryngology, Chicago, Ill.

Oct. 15: Fifth annual professional symposium on Recent Advances in Renal Disease, Kidney Foundation of Illinois, LaSalle Hotel, Chicago.

Oct. 16–17: American Association for Automotive Medicine, Mayo Auditorium, Minneapolis, Minn.

Oct. 17–18: General Practitioners In-House Conference, University of Iowa, Iowa City.

Oct. 18–23: Annual meeting, American Academy of Pediatrics, Palmer House Hotel, Chicago.

Oct. 23–25: Conference on Surgery, University of Iowa, Iowa City.

Oct. 29–30: American Association for the Study of Liver Disease, Chicago, Ill.

Oct. 29–Nov. 2: American College of Chest Physicians, Chicago, Ill.

Nov.: American Society of Therapeutic Radiologists, Chicago, Ill.

Nov. 2–5: International Symposium on Atherosclerosis, Chicago, Ill.

Nov. 3–5: Clinical Reviews (to be repeated on Nov. 10–12), Mayo Clinic and Mayo Foundation, Rochester, Minn.

Nov. 3–14: Postgraduate course in Laryngology and Bronchoesophagology, Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago.

Nov. 8–9: North Central Medical Conference, St. Paul Hilton, St. Paul Minn.

Nov. 10–12: Clinical Reviews (repeat of Nov. 3–5), Mayo Clinic and Mayo Foundation, Rochester, Minn.

Nov. 11–15: American College of Preventive Medicine, Detroit, Mich.

Nov. 21–22: Workshop on the Delivery of Medical Care in the 1970s, Institute of Medicine of Chicago, Ambassador Hotel, Chicago.

Nov. 28–29: Head and Neck Radiology Conference, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Nov. 30–Dec. 5: Radiological Society of North America, Chicago, Ill.

1969 OTHERS

Sept. 5–7: Cardiovascular Symposium, Tidewater Heart Association, Williamsburg, Va.

Sept. 8–12: Fifth International Congress of Dietetics and 52nd annual meeting of American Dietetic Association, Sheraton–Park Hotel, Washington, D.C.

Sept. 24–26: Cleveland Course in Pulmonary Diseases, Case Western Reserve University School of Medicine in cooperation with St. Luke's Hospital, American Thoracic Society, and others, Cleveland, Ohio.

Sept. 28–Oct. 3: Annual meeting Michigan State Medical Society, Detroit.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Sept. 29–Oct. 2: Annual scientific assembly, American Academy of General Practice, Philadelphia, Civic Center, Pa.

Sept. 29–Oct. 3: Hospital Medical Staff Conference, University of Colorado School of Medicine, Estes Park.

Oct. 6: International Symposium on Early Disease Detection, Elkhart, Ind.

Oct. 6–10: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 7–11: Western Conference of Prepaid Plans, Sun Valley, Idaho.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 22–24: 16th Western Cardiac Conference, University of Colorado Medical Center, Denver, Colo.

Oct. 27: Oral Cancer Seminar, University of Colorado School of Medicine, Denver.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 12–15: Postgraduate conference, Mound Park Hospital Foundation and University of Florida, Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Nov. 17–21: Course in Neuroradiology with Clinical and Pathological Correlation, New York University Post-Graduate Medical School, New York.

Nov. 19–21: Emergency Service Procedures, University of Colorado School of Medicine, Denver.

Nov. 20: Annual Membership Meeting, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Dec. 8–11: Sixth Annual New Orleans Course on Pulmonary Function in Health and Disease, American Thoracic Society with others, Louisiana State University School of Medicine Auditorium, New Orleans.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium). Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psychosomatic Seminars), to South Pacific.

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1969 AMA

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

May 11–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 NEIGHBORING STATES

Mar. 16–20: Clinical Problems in Internal Medicine, American College of Physicians, Cleveland, Ohio.

Mar. 23–26: Neurology and the Internist, American College of Physicians, Rochester, Minn.

Mar. 30–Apr. 3: Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, American College of Physicians, Ann Arbor, Mich.

June 8–12: Internal Medicine, 1970—Old Principles, New Practice, American College of Physicians, Iowa City, Iowa.

June 15–17: Blood Transfusion Therapy and Related Immunology, American College of Physicians, East Lansing, Mich.

Oct. 5–9: 53rd Annual Meeting, American Dietetic Association, Detroit, Mich.

1970 OTHERS

Jan. 18–24: Sixteenth Annual General Practice Review, University of Colorado School of Medicine, Denver.

Feb. 2–6: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Mar. 9–27: Course for physicians in Occupational and Environmental Medicine, New York University Post-Graduate Medical School, New York.

Apr. 6–10: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Apr. 26–30: First International Congress on Group Medicine, Winnipeg, Manitoba, Canada.

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

Dec. 6–11: Second International Clean Air Congress, Washington, D. C.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1971 OTHERS

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the **Journal of the American Medical Association.**

Disease Detection Symposium

An international symposium on early disease detection will be held in Elkhart, Ind., Oct. 6 under the chairmanship of Dr. Morris F. Collen, director of Medical Methods Research, Permanente Medical Group, Oakland, Calif.

The symposium will be conducted under the sponsorship of Ames Company, Division of Miles Laboratories, Inc., Elkhart.

Registration is open to all physicians, without fee. Advance registration forms can be obtained from Disease Detection Information Bureau, 3553 W. Peterson Ave., Chicago, Ill. 60645.

Symposium on Renal Disease

The fifth annual symposium on Recent Advances in Renal Disease will be presented Oct. 15 in the La Salle Hotel, Chicago, by the Kidney Foundation of Illinois.

Guest speakers include: *Dr. Milton Elkin,* professor and chairman, Department of Radiology, Albert Einstein College of Medicine; *Dr. Lawrence Freedman,* associate professor of medicine, Department of Medicine, Yale University Medical Center; *Dr. John T. Grayhack,* professor and chairman, Department of Urology, Northwestern University Medical School; *Dr. Robert H. Hepinstall,* professor of pathology, Johns Hopkins University, School of Medicine; *Dr. Calvin Kunin,* chairman, Department of Preventive Medicine, University of Virginia; and *Dr. George Schreiner,* professor of medicine, Georgetown University, School of Medicine.

Topics will include: Urinalysis and Tests of Renal Function, Recent Advances in Radiology of the Kidney, Recent Advances in Pathology with Particular Reference to Renal Biopsy, Recent Advances in the Understanding and Treatment of Bacteriuria and Pyelonephritis, The Interrelationship of Pyelonephritis and Hypertension, The Urologic Approach to Urinary Tract Infections and Stones, and Panel Discussions.

Registration fee: $15.00, including luncheon; $6.00 for students, interns, and residents. Send registrations to Kidney Foundation of Illinois, 127 North Dearborn Street, Room 701, Chicago, Ill. 60602.

This program is acceptable for six hours of elective credit by the American Academy of General Practice. The application for this credit may be obtained at the symposium registration desk on Oct. 15.

Course in Pulmonary Function

The 6th Annual New Orleans Course on Pulmonary Function in Health and Disease will be presented by the American Thoracic Society, Louisiana Thoracic Society, Louisiana State University School of Medicine, Tulane University School of Medicine, and Alston Ochsner Medical Foundation at the Louisiana State University School of Medicine Auditorium in New Orleans Dec. 8–11.

Fee: $100 for physicians and PhDs; $50 for all others. (Members of the ATS and physicians supported by Christmas Seal scholarships, $75.)

Contact: Miss Joan Ritchie, Course Registrar, Suite 407, Louisiana Thoracic Society, 305 Baronne St., New Orleans, La. 70112; tel. 504/523–3093.

Conception Control—New York

A seminar for nurses and other professionals focusing on conception control will be conducted Sept. 17–19 at New York University Medical Center, 550 First Avenue, New York, N. Y. 10016.

Sponsor is the New York University School of Medicine, Department of Obstetrics and Gynecology, Division of Family Planning.

THE FALL PROGRAM

Wisconsin Surgical Society

SEPTEMBER 16–23, 1969

INNSBRUCK, AUSTRIA

THURSDAY, SEPTEMBER 18

REGISTRATION: Committee meetings, and orientation for members, at Hotel Europa, Innsbruck, Austria

FRIDAY, SEPTEMBER 19

8:00 Registration in the Auditorium of the Medical School, University of Innsbruck

9:00–1:00 Scientific program
Presiding: Professor Dr. Paul Huber
Chairman of local arrangements: Professor Dr. Bruno Haid

1. **Professor Dr. Paul Huber:** Problems in the Treatment of Malignant Struma
2. **Dozent Dr. Georg Riccabone:** Nuclear Medicine
3. **Oberarzt Dr. Günther Philadelphy:** Wire Suturing of Tibial Fractures
4. **Professor Dr. Karl Kloss:** New Methods in the Treatment of Cranial Cerebral Trauma
5. **Professor Dr. Hans Marberger:** Diagnosis and Therapy in the Trauma of Kidney and Urinary Passages
6. **Dozent Dr. Klaus Bandhauer:** The Operative and Conservative Therapy of Vesico-ureteral Reflux

SATURDAY, SEPTEMBER 20

Entire group going to Otz Valley. Special excursions for members to include skiing, hiking, golf, tennis, and activities as desired. Tirolerabend at Hotel Drei Mohren in Otz.

SUNDAY, SEPTEMBER 21

Free Day

MONDAY, SEPTEMBER 22

9:00–12:00 Program by members of the Wisconsin Surgical Society

1. **Dr. A. R. Curreri:** The Use of Adjuvant Chemotherapy and Second Look Operation in the Control of Colon Carcinoma
2. **Dr. Fred J. Ansfield:** Current Status of Chemotherapy in Advanced Breast Cancer
3. **Dr. William A. Kisken:** Problems in Renal Transplantation

Intermission

4. **Dr. Charles Yale:** Surgical Research at the University of Wisconsin Gnotobiotic Lab
5. **Dr. Ernest Henshel:** Studies of Renal Blood Flow During Anesthesia
6. **Dr. E. A. Bachhuber:** Modern Approach to the Teachings of Surgical Anatomy

TUESDAY, SEPTEMBER 23

7:00 Annual Banquet in Hotel or Guild Hall (final arrangements not yet completed)

Fall Pediatric Day—Madison

The annual "Fall Pediatric Day" of the Wisconsin Academy of Pediatrics and the University of Wisconsin Department of Pediatrics will be held Oct. 3 at the Wisconsin Center in Madison.

Dr. William Nyhan, professor and chairman of the Department of Pediatrics, University of California at San Diego, will be the main speaker.

Clinical Reviews—Mayo Clinic

The Staff of the Mayo Clinic and the Faculty of the Mayo Foundation are presenting Clinical Reviews this year in the fall. The dates are Nov. 3, 4, and 5, and again on Nov. 10, 11, and 12. Because of the large number attending in past years, the two identical sessions have been planned as in the past.

Clinical reviews are a program of lectures and discussions on problems of general interest in medicine and surgery. The program is acceptable for credit by the American Academy of General Practice and the College of Family Physicians of Canada.

Registration fee: $20.00. Those wishing to attend should communicate with M. G. Brataas, Mayo Clinic, Rochester, Minn. 55901, indicating which session they would prefer to attend.

Workshop on Clinical Hypnosis/Hypnotherapy

The American Society of Clinical Hypnosis–Education and Research Foundation is sponsoring a teaching Workshop on Clinical Hypnosis and Hypnotherapy with the Department of Neurology and Psychiatry of the University of Minnesota at the Pick–Nicollet Hotel, Minneapolis, Minn., Sept. 25–27.

Milwaukee Psychiatric Hospital Symposium

"Women and the Future" is the subject of the Sixth Annual Symposium sponsored by the Milwaukee Psychiatric Hospital, Wauwatosa, at the Pfister Hotel in Milwaukee, October 3–4.

Dr. Raymond Headlee, president of the hospital medical staff, is program chairman. He has announced that "the symposium will present a dialogue among four guests of national renown."

Program participants will include Martha Peterson, president of Barnard College, New York City; Catherine Covert Stepanek, associate professor of journalism, Syracuse University; Dr. Elizabeth Koontz, director of Women's Bureau, U. S. Department of Labor, Washington, D. C.; and Dr. Robert Jay Lifton, professor of psychiatry, Yale University.

Other program participants, serving either as discussants of papers or reactors during dialogue periods, include Dr. Raymond McCall, professor of psychology, Marquette University; Dr. Inez Ninsvark, dean, School of Nursing, University of Wisconsin–Milwaukee; and two mothers, one who has young children and one who has grown children.

The symposium is planned as a highlight of the hospital's 85th year of operation. It will be presented in conjunction with the Department of Psychiatry, Marquette School of Medicine.

Conference on Stroke—Minneapolis

A conference on stroke will be held Sept. 19–20, Pick–Nicollet Hotel, Minneapolis, Minn. The conference—sponsored by The American Rehabilitation Foundation, under a grant from Social and Rehabilitation Services, U. S. Department of Health, Education, and Welfare—reports the results of a four-year research project conducted at the Kenny Rehabilitation Institute entitled "Rehabilitative Predictors in Completed Stroke."

Sessions include measurements of improvement in completed stroke, rehabilitative predictors in completed stroke, environmental correlates of differential outcomes, and implications for future research.

Fee: $20; registration open to all disciplines. Contact: Dr. Thomas P. Anderson, American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minn. 55404.

Great Plains Heart Symposium—Iowa

A Cardiovascular Symposium sponsored by the Iowa Heart Association in cooperation with the Great Plains Heart Associations will be held at The University of Iowa Health Center Friday and Saturday, Sept. 19–20.

Speakers at the opening general session will be Dr. Campbell Moses, New York, N. Y., who will discuss "Risk Factors in Cardiovascular Disease" and Dr. J. Willis Hurst, Atlanta, Ga., who will speak on "Bedside Diagnosis of Cardiovascular Disease."

Simultaneous sessions on pediatric cardiology, auscultation of the heart, and laboratory aids in cardiovascular disease will follow the first general session. Moderators will be, respectively, Dr. Paul K. Mooring, Omaha, Neb., Dr. Earnest O. Theilen, U of I, and Dr. Kenneth G. Berge, Rochester, Minn.

The luncheon speaker will be Dr. William B. Bean, professor and head of the U of I Department of Internal Medicine.

Afternoon topics and moderators for simultaneous sessions will be "Remedial Heart Disease," Dr. Brent M. Parker, St. Louis, Mo.; "Specialized Techniques," Dr. Frank W. Kroetz of the U of I; and "Cardiovascular Drugs," Dr. John A. Spittell, Jr., Rochester, Minn.

General session speakers will be Dr. Leon Goldberg, Atlanta, Ga., who will speak on "Sympathetic Drugs in the Treatment of Shock" and Dr. Arthur C. Beall, Jr., who will discuss "Major Vessel Surgery."

"Curbstone Consultations" on cardiovascular drugs, treatment of shock, medical vs. surgical treatment of dissecting aneurysms of the aorta, auscultation pearls, tips in prevention of coronary artery disease and stroke, pediatric cardiac radiology, and problem electrocardiograms, will be held Friday evening.

A general session on heart failure Saturday morning will consider prevention, bedside diagnosis, digitalis and other drugs, and surgical therapy.

COMING CONFERENCES AT THE UNIVERSITY OF IOWA

Oct. 3–4 Urology
Oct. 17–18 General Practitioners In-House Conference
Oct. 23–25 Surgery

American Dietetic Association Congress

Sixty countries will be represented at joint meetings of The 5th International Congress of Dietetics and the 52nd Annual Meeting of The American Dietetic Association to be held in Washington, D. C., Sept. 8–12. Setting the tone with the theme DIETETICS IN A CHANGING WORLD, the Congress will appraise the role of dietitians and nutritionists in meeting the health needs of tomorrow's world.

The international assembly will present research and findings of worldwide scope, exploring anticipated changes in food, health, and social structures in the world. Speakers from throughout the world will address an estimated 6,000 registrants with major sessions simultaneously translated into French, German, Spanish, and English. Headquarters for the sessions and exhibition will be The Sheraton–Park Hotel.

Oral Cancer Seminar—Denver

A one-day postgraduate course on Oral Cancer will be held Oct. 27 in Denver, Colo., by the University of Colorado School of Medicine.

The course is designed for practicing dentists and physicians and will include topics such as "The Nature of Oral

Cancer," "Epidemiology and Clinical Diagnosis of Oral Cancer," "The Correlation of Microscopic and Clinical Features of Oral Lesions," "The Role of Biopsy and Cytology in the Diagnosis of Oral Cancer," "The Treatment of Oral Cancer," "Osteoradionecrosis," and "Prosthetics for Oral and Facial Defects."

For further information: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

Interstate Scientific Assembly—Cleveland

The 54th Annual Scientific Assembly of the Interstate Postgraduate Medical Association will be held Oct. 13–16 in Cleveland, Ohio.

The traditionally diversified program of instruction will be presented in an interesting and concise manner and be directly applicable to medical practice, according to the Association's president, Dr. Leonard L. Lovshin, who is a graduate of the University of Wisconsin Medical School and was a football star during the time he was in medical school in Madison.

Wisconsin trustees of the Association are Drs. John M. Bell, Marinette; Nels A. Hill, Madison; and William B. Hildebrand, Menasha.

Of special note is the dinner program Oct. 15 when Dr. Morris Fishbein, president-elect of Interstate Postgraduate Medical Association, will address his colleagues on "The Evolution of Postgraduate Medical Education."

The program is acceptable for 22 prescribed hours by the American Academy of General Practice.

An exciting program of social events for wives also has been planned.

Registration fee: $15. For full program and hotel forms contact Roy T. Ragatz, Executive Director, 307 N. Charter St., Madison, Wis. 53715.

ANNUAL MEETING AND SCIENTIFIC PROGRAM

Wisconsin Society of Internal Medicine

Kahler's Inn Towne Motel
Lake Delton

THURSDAY MORNING, SEPTEMBER 11

10:00 ALL-EVENT GOLF TOURNAMENT, Dellview Golf Course

FRIDAY MORNING, SEPTEMBER 12

9:00 SYMPOSIUM ON LIVER DISEASE: Bilirubin and Bile Acids
Henry C. Pitot, MD, PhD, Professor of Oncology and Pathology; Chairman, Department of Pathology, University of Wisconsin Medical School, Madison

9:20 Hepato–Renal Syndrome
William B. Baldus, MD, Department of Internal Medicine, Mayo Clinic, Rochester, Minn.

9:40 Lithocolic Acids
James B. Carey, Jr, MD, Professor of Medicine, University of Minnesota Medical School, Minneapolis

10:00 QUESTION AND ANSWER PERIOD

10:15 COFFEE BREAK

10:30 The Pill As a Cause of Hepatitis, A Case Report
William C. Boake, MD, Assistant Professor of Medicine, University of Wisconsin Medical School, Madison

10:50 Chronic Cholangiolytic Hepatitis
Mitchell A. Spellburg, MD, Chairman, Department of Gastroenterology, Michael Reese Hospital, Chicago, Ill.

11:10 Chronic Hepatitis
Leslie J. Schoenfield, MD, Department of Internal Medicine, Mayo Clinic, Rochester, Minn.

11:30 QUESTION AND ANSWER PERIOD

12:00 LUNCHEON—ANNUAL MEETING WSIM
President: **James Manier,** MD, Marshfield, presiding
Speaker: **Clyde C. Greene,** Jr, MD, President, American Society of Internal Medicine, San Francisco, Calif.
Topic: ASIM and Your Future
There will also be comments by **Charles F. Downing,** MD, ASIM Trustee, Decatur, Ill.

FRIDAY AFTERNOON, SEPTEMBER 12

2:00 THE WILLIAM S. MIDDLETON LECTURE: Current Problems in Medical Education
M. Marvin Pollard, MD, Immediate Past President, American College of Physicians, Ann Arbor, Mich.; and Professor of Medicine, University of Michigan Medical School

3:00 Computers in Medicine
Warner Slack, MD, Assistant Professor of Medicine and Computer Science, University of Wisconsin Medical School, Madison
Frank Larson, MD, Professor of Medicine, University of Wisconsin Medical School, Madison
Guerdon Combs, MD, Department of Internal Medicine, Marshfield Clinic, Marshfield

FRIDAY EVENING, SEPTEMBER 12

Wisconsin Dells Charter Boat Trip. Refreshments and banquet, with music on board.

SATURDAY MORNING, SEPTEMBER 13

8:30 BREAKFAST
Remarks: The American College of Physicians—**M. Marvin Pollard,** MD

9:40 SYMPOSIUM ON INFECTIOUS DISEASES
Karl F. Doege Recognition Lecture: Challenge of Critical Care
Burton A. Waisbren, MD, Associate Clinical Professor of Medicine, Marquette School of Medicine, Milwaukee

10:00 Principles and Practice of Antibiotic Therapy
Allan C. Kind, MD, Assistant Professor of Medicine, University of Wisconsin Medical School, Madison

10:30 Acute Viral Upper Respiratory Disease Syndrome
Harry B. Harding, MD, Evanston Hospital, Evanston, Ill.

10:50 Infections in the Aged and Immunologically Comprised Host
Michael W. Rytel, MD, Associate Professor of Medicine and Chief, Section of Infectious Disease, Marquette School of Medicine, Milwaukee

11:10 Pyelonephritis, Urine Culture Technique
William J. Holloway, MD, Director, Infectious Disease Research Laboratory, Wilmington Medical Center, Wilmington, Del.

11:30 QUESTION AND ANSWER PERIOD

Maternal and Child Health Programs

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley has announced the following postgraduate programs for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. These programs all lead to the degree of Master of Public Health. Tax-exempt fellowship support is available.

Maternal and Child Health. A 9-month program in planning, organizing, and operating comprehensive health services for mothers and children.

Family Planning. A 9-month academic program providing intensive work in school health as part of the general graduate preparation of maternal and child health specialists.

School Health. A 9-month academic program providing intensive work in school health as part of the general graduate preparation of maternal and child health specialists.

The Multiply Handicapped and Mentally Retarded Child. A 21-month academic and clinical program in planning, organizing, and operating community services for children with multiple handicaps, including mental retardation.

Career Development Programs. Three-year academic and residency programs consisting of one year of academic training leading to the degree of Master of Public Health combined with residency training in Pediatrics or Obstetrics–Gynecology.

Applications are now being accepted for the group entering in July or September, **1970.** For information, write to Helen M. Wallace, MD, School of Public Health, University of California, Berkeley, Calif. 94720.

Air Pollution Symposium—New York

The Fifth Annual Symposium on Air Pollution and Respiratory Disease, sponsored by the New York State Action for Clean Air Committee, will be held on Thursday, Oct. 23, at New York University Medical Center, 550 First Avenue, Manhattan. The Medical Center is a co-sponsor of the Symposium, together with Bristol Laboratories and the Queensboro Tuberculosis and Health Association.

At the morning session, scientists will review on-going research on the effects of air pollution on health. The afternoon program will include discussions of future alternatives to some of today's air-polluting practices.

Further information about the Symposium may be obtained from the New York State Action for Clean Air Committee, 105 East 22nd St., New York 10010; or any of the cosponsors.

Cardiac Conference—Denver

The 16th Western Cardiac Conference is scheduled for Oct. 22–24 at the University of Colorado Medical Center in Denver. It will feature a Symposium on the Critically Ill Heart Patient with a theme, "Severe Cardiac Problems."

Topics for discussion include Controversies in Cardiogenic Shock, Mechanisms in Sudden Death, Monitoring Systems and What They Can Contribute, New Cardiac Drugs, Traumatic Heart Disease, New Operations for Previously Inoperable Lesions, Transplantation of the Heart, Surgical Treatment of Massive Myocardial Infarction, Mechanical Assist Devices for Failing Circulation, and Other Related Topics.

Contact: Colorado Heart Association, 1375 Delaware Street, Denver, Colo. 80204.

International Congress on Group Medicine

"New Horizons in Health Care" is the theme of the First International Congress on Group Medicine to be held April 26–30, 1970, in Winnipeg, Manitoba, Canada.

Inquiries are invited and should be addressed to: The First International Congress on Group Medicine, 425 St. Mary Avenue, Winnipeg 1, Manitoba, Canada.

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

July 1, 1969–December 31, 1969

STATE DEPARTMENT OF PUBLIC INSTRUCTION

BUREAU FOR HANDICAPPED CHILDREN

MADISON, WISCONSIN 53702

Location	*Date*	*Location*	*Date*
Stevens Point	August 13	Kenosha	October 15, 16
Ashland	August 21, 22	La Crosse	October 22, 23
Manitowoc	August 27, 28	Chippewa Falls	October 29, 30
Racine	September 10, 11	Rhinelander	November 5, 6
Eau Claire	September 24, 25	Sheboygan	November 12, 13
Superior	October 7		

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examinations are sent to the referring physician following clinic.

REFERRAL FORMS: Referral forms may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for each clinic so when requesting same be sure to state how many forms are needed and for which clinic. It is important that we know well in advance the number desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 126 Langdon Street, Madison, Wisconsin 53702.

Course in Occupational Medicine

A full-time three-week course for physicians in Occupational and Environmental Medicine is being offered by the New York University Post-Graduate Medical School from Mar. 9 through Mar. 27, 1970. It will be given by the faculty of the department of environmental medicine under the direction of David H. Goldstein, MD.

The first week will be devoted to general and administrative aspects of occupational medicine, including history and philosophy, organization, occupational diseases, workmen's compensation and other legal and insurance subjects. In addition, this period will be concerned with the relations of the industrial physician with other health professionals, management, workers, unions and the community. These lectures will be held at the New York University Medical Center in New York City.

The second and third weeks will cover basic scientific and clinical aspects, including toxicology, industrial hygiene, radiobiology, related community pollution problems, epidemiology and biostatistics. The sessions during these two weeks will be given at the Sterling Forest Conference Center near Tuxedo, New York. The facilities of the adjacent Anthony J. Lanza Laboratories of the New York University Institute of Environmental Medicine will also be used. It is possible to enroll for just the second and third weeks if desired.

Application should be made by Nov. 1, 1969, as enrollment is limited to a maximum of 25 physicians. Tuition for the full three-week course is $375, and for the two-week segment (Mar. 16–27) is $250. Applications and requests for further information should be sent to the Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, New York 10016.

Correlative Neuroradiology—New York

A postgraduate course in neuroradiology with clinical and pathological correlation will be held Nov. 17–21 by New York University Post-Graduate Medical School.

The curriculum includes: comprehensive coverage of skull and spine, cerebral angiography, pneumoencephalography and ventriculography, studies of the spinal cord by myelography and angiography, brain scanning and other isotope studies, and technical aspects and special techniques.

Tuition fee: $150; payable in advance when submitting application. Residents and fellows in approved training programs will be eligible for a $75 fee.

For applications: Office of the Recorder, New York University, Post-Graduate Medical School, 550 First Avenue, New York, N. Y. 10016.

Mayo Clinic Postgraduate Course

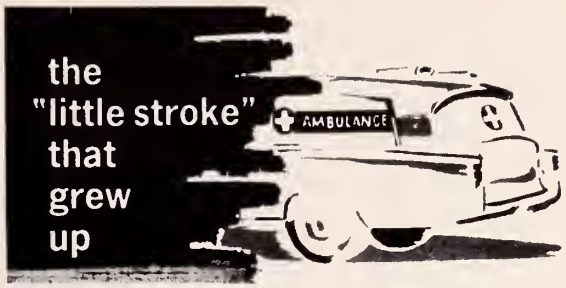
A postgraduate course on Venous and Lymph Disorders of the Lower Extremity will be held Sept. 18–19 at Mann Hall, Medical Sciences Building, Rochester, Minn., under direction of the Mayo Clinic and Mayo Foundation.

The course, as announced by the secretary, M. G. Brataas, will focus attention on the common, yet significant, problems of venous and lymphatic disorders of the lower extremity. These disorders, often subtle, may go unrecognized and therefore may not be adequately treated. Topics on the etiology and diagnosis of their many aspects will be presented, stressing current concepts of medical and surgical management.

Tuition fee: $60. Attendance limited to 150 physicians. Registration to: Postgraduate Courses, Mayo Clinic–Mayo Foundation, Rochester, Minn. 55901.

Other Mayo courses to be offered in the near future include:

Vascular Diseases—Oct. 1–4
Clinical Reviews—Nov. 3–5 and Nov. 10–12
Neurology for Internists—Mar. 23–26, 1970
Heart Failure—May 14–16, 1970. □



prevent the progression from "little strokes" to serious cerebral vascular accident with hescor

Little strokes frequently precede the serious, often fatal Cerebral Vascular Accident. Early recognition and treatment of these "little strokes" may prevent additional cerebral damage.

Gale and Thewlis reported, "Many cerebral accidents may be avoided if adequate amounts of capillary protective factors — hesperidin complex and ascorbic acid are provided."[1]

HESCOR contains purified hesperidin — the clinically proven — biologically active, citrus bioflavonoid plus ascorbic acid. Purified hesperidin contains 80% hesperidin while hesperidin complex contains from 62% to 68% hesperidin[2]. HESCOR's higher potency assures capillary integrity.

When double vision, transitory dizziness, paresthesia or ataxia point to cerebral capillary fragility — prescribe high potency HESCOR tablets — for safe, proven protection against future cerebral vascular accidents.

hescor tablets

HESCOR contains: Hesperidin Purified, 100 mg., and Ascorbic Acid, 100 mg. Dose: for active capillary hemorrhage or threatened abortion, 2 tablets t.i.d.; for prevention of capillary hemorrhage and to maintain normal capillary function, 1 tablet t.i.d. Contraindications: none.

[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

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WISCONSIN MEDICAL JOURNAL
Vol. 68, No. 8 AUGUST 1969

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Society Encourages Financial Aid for Marquette

SMS President Issues Personal Appeal

Aug. 11th 1969

Dear Doctors:

At a time when our health needs require the expansion of our two medical schools and the creation of a new additional school, it is unthinkable that we can permit Marquette School of Medicine to close for lack of funds. No one knows better than overworked physicians what the closing of one of our two medical schools means to the health status of our State.

I appeal to all physicians of Wisconsin, dedicated to the public health and to medical education, to give generous financial support now to save Marquette School of Medicine.

Sincerely,
Robert E. Callan M.D.

The drive to save Marquette School of Medicine, kicked-off by the decision of the Council of the State Medical Society to go to the public with a series of full-page and quarter-page advertisements, is beginning to pay dividends.

But, the goal is still a long way off, according to Marquette medical school officials.

Although the financial plight of the school has been known widely for a long time, news stories in mid-July shocked the public with the report that the school might close "within a month."

Officers of the Society, meeting in New York with the AMA House of Delegates, consulted by telephone with members of the Council and decided to seek public support for the school through advertisements sponsored by the State Medical Society of Wisconsin. The first of these was published on July 25.

Since then Marquette officials say that some $150,000 has been raised. But a total of $600,000 is required just to keep the school going until October 1. It is hoped that by that time some decision can be reached by the State Legislature for support. Without such aid, it appears the school will close.

As the Green Sheet goes to press, a blue ribbon committee called the "Citizens Committee to Save Marquette School of Medicine" has been formed and widespread efforts are being undertaken with alumni and others.

MARQUETTE SCHOOL OF MEDICINE
CRAMER MEMORIAL BUILDING
561 NORTH FIFTEENTH STREET
MILWAUKEE, WISCONSIN 53233

OFFICE OF THE DEAN

July 31, 1969

C. H. Crownhart, Secretary - State Medical Society of Wisconsin
330 East Lakeside Street
Madison, Wisconsin 53701

Dear Mr. Crownhart:

On behalf of the Marquette medical school family - students, faculty and Directors - I am writing to thank you as a member of the Council of the State Medical Society for the support which the State Medical Society has extended to the Marquette medical school in connection with the need of the medical school for state assistance for continued operation.

As you know, the Marquette medical school has faced large operating deficits in recent years. As the medical school is, with the medical school of the University of Wisconsin, a major supplier of the physician manpower of the state, we feel that its continued operation and growth is of very vital importance to the state.

Like other private medical schools, the Marquette medical school has faced the need to operate expanding programs without a corresponding growth in endowment and tuition income. The present programs of the medical school are of average size for all U.S. medical schools in terms of numbers of faculty, numbers of students and annual expenditure. The 1968-69 expenditure of the medical school for all of its programs was $10,500,000, exactly the national mean.

The deficits of the medical school have reached $1,500,000 annually. For a number of years, the medical school's deficits have been funded by gifts from alumni, the AMA Education Fund, industry, and to a major degree by liquidating capital assets of the medical school. At present, all marketable assets have been sold, and it is impossible for the medical school to sustain its programs, or to increase its programs to meet growing health care needs without state assistance. The assistance requested from the state legislature represents

about 12% of the present operating budget of the medical school, but it is a critical 12% directly related to education costs as distinguished from research and patient care costs. As you understand, research and patient care funds are not directly applicable to the support of teaching programs. State assistance in the amount of approximately 12% of the present operating budget of the medical school is urgently needed for the continued operation of the medical school.

The discussions concerning state aid have proceeded well, but have taken somewhat more time than was initially contemplated. In 1965, the Directors of the medical school stated publicly that the medical school could not continue to function without state aid. For some time, it has been evident that the resources of the medical school were not sufficient to sustain its operation beyond June 30, 1969. The present financial crisis of the medical school reflects the depletion of its marketable resources, and the fact that the continuation of its programs until such time as state aid is available will be dependent upon gifts to support its present operating deficit of approximately $200,000 a month.

We believe that the needed funds are most likely to be provided in part by alumni of the medical school who have supported the school most generously in past years, in part by the medical profession at large, and to an important extent by industry. The Directors of the medical school have decided that it is important that their needs be frankly and publicly stated so that all concerned will be well informed.

The Directors of the medical school and the faculty greatly appreciate the support of the Council of the State Medical Society reflected by the recent advertisement on behalf of the medical school which appeared in a number of our newspapers. We greatly appreciate the assistance of the State Medical Society and will need its continued assistance to carry on our work.

Sincerely yours,

Gerald Kerrigan

Gerald A. Kerrigan, M.D.
Dean

GAK:ch

Unless the Marquette School of Medicine gets financial help now... it may be forced to close its doors!

CAN THE HEALTH OF THE PEOPLE OF WISCONSIN AFFORD THIS TRAGIC LOSS?

A fact that may not be fully realized by the citizens of Wisconsin is that we are in a period of deepening crisis with regard to the supply of physicians. Yet in the face of this crisis we are confronted with the possible closing of one of Wisconsin's two medical schools. This is a crisis that can affect you and your community personally!

The Marquette School of Medicine contribution. Nearly 32 per cent of all the state's practicing physicians have graduated from the Marquette School of Medicine. The people in nearly 190 cities and towns in Wisconsin depend entirely or in part on Marquette School of Medicine graduates for their medical care.

The financial problem. Although tuition at Marquette School of Medicine is $1750 per year, this covers less than one third of the cost of educating a medical student. The school must find other sources to make up the balance. Faced with serious financial troubles in 1967, the School disassociated itself from Marquette University. Since then, the State Legislature has considered providing state aid to help the School. Thus far, no funds have been appropriated. It is hoped the Legislature will do so. But time has already run out. The Medical School's endowment fund has been totally exhausted. Costs are running about $200,000 a month.

The need is now! You can help to avert this threat to the health of the people. Your contribution is important.

Help Save Marquette School of Medicine

All contributions are tax deductible.

Send dollars, dimes, pennies and pledges to the address on this coupon.

Your contribution will be gratefully acknowledged. Act now!

MARQUETTE SCHOOL OF MEDICINE
561 North 15th Street, Milwaukee, Wisconsin 53233

Enclosed please find my contribution: ☐ Check ☐ Money Order ☐ Pledge

_____ (amount)

NAME_____

ADDRESS_____

CITY_____

COMPANY_____
(if appropriate)

STATE MEDICAL SOCIETY OF WISCONSIN
MEDICINA NUSQUAM NON EST

This urgent plea for help is published on behalf of the Marquette School of Medicine as a service to the public health by the State Medical Society of Wisconsin.

Marquette's Closing Would Mean . . .

. . . loss of the largest intern and residency training programs in the state, both of which affect physicians' choices about locating in the area.

THIS BEAUTIFUL gold timepiece, more than 50 years old, was long a proud and useful possession of the late Harry E. Kasten, M.D. of Beloit. In presenting it for the Watch Collection of the CES Foundation of the State Medical Society, Mrs. Kasten expressed the hope that other physicians would add to the collection in memory of their families or friends. If you should be interested in making such a donation, contact Mr. T. J. Doran, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Wisconsin State Journal

Page of Opinion

MONDAY, AUGUST 4, 1969

HEALTH IN JEOPARDY

Marquette Meds Need Help

The State Medical Society of Wisconsin is making an important plea on behalf of the Marquette Medical School.

The society is putting it bluntly: "Unless the Marquette school of medicine gets financial help now, it may be forced to close its doors.

"Can the health of the people of Wisconsin afford this tragic loss?"

The answer is no. Resoundingly no.

Wisconsin has only two medical schools, Marquette in Milwaukee and the University of Wisconsin medical school in Madison.

It's a fact of life that the greatest source of doctors in a state is the state medical school. Students come to a state, like it, and stay. Or subsidies require their return to the state.

Marquette produces about the same number of doctors as the University, but it produces more who stay and more general practitioners. Nearly 32 per cent of all doctors in Wisconsin are Marquette graduates.

In 1966, some 26 per cent of the general practitioners of the state were Marquette graduates, as compared with 19 per cent from the University.

And this is the group which is vital to the smaller cities and towns.

The situation at Marquette follows a national trend. Tuition covers only about one-third of the cost of an education which is more expensive than most. The medical school begins to bankrupt the private school, and the private school is in trouble.

This had happened to Marquette by 1967, and the medical school was separated from the university. Aid is now being sought in the Legislature, waiting the outcome of a Supreme Court hearing on Sept. 8 to determine legality of a bill to give state support to the private school.

Time, however, is running out. It's estimated that, by the end of this month, Marquette Medical School may have to close its doors.

The medical society is seeking citizen financial help.

The project is worthy. The school cannot be allowed to slip down the drain, for this loss would mean irreparable damage to the health care of all people of Wisconsin.

REPRINTED

Council Supports Marquette

The Council of the State Medical Society of Wisconsin, meeting in official session August 3, 1969, adopted the following resolution:

Resolution Concerning Marquette School of Medicine

Recognizing that the Marquette School of Medicine has played an essential role in educating physicians and other personnel and that the need to expand medical services is more vital than ever to the health of Wisconsin residents today—which facts are thoroughly documented according to the Governor's Task Force on Medical Education; and

Recognizing that the State Medical Society of Wisconsin has in the past evidenced its support for the continuance of the Marquette School of Medicine, and

Recognizing the critical financial situation of the Marquette School of Medicine which if not immediately relieved may lead to the school's closing;

Be it resolved:

1. That the Councilors and Officers of the State Medical Society today express their recognition that the closing of the Marquette School of Medicine would have calamitous consequences for the health of Wisconsin residents, and

2. That the State Medical Society use its energies, resources, and talents to solicit and secure help from all segments—public and private—in Wisconsin and anywhere else to keep the Marquette School of Medicine operating and to enable it to expand its program in line with the Governor's Task Force recommendations.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1969 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

Council Approves Guidelines for Nurses in Care of Patients in Coronary Care Units

This statement of guidelines for the nurse in the coronary care unit was adopted by the Council of the State Medical Society in meeting August 2, 1969. It had previously been adopted by the other organizations or agencies participating in its development. Copies are available from the State Medical Society.

GUIDELINES FOR THE ROLE OF THE REGISTERED PROFESSIONAL NURSE IN THE CARE OF PATIENTS WITH CARDIOVASCULAR DISEASE IN THE CORONARY CARE UNIT

The following joint policy statement regarding the role of the nurse in the coronary care unit was developed by a committee composed of representatives from The State Medical Society of Wisconsin, the Wisconsin Nurses Association, Inc., the Wisconsin Hospital Association, the State of Wisconsin Board of Nursing, and the State of Wisconsin, Division of Health.

This policy statement should be used as a guideline, and will not provide immunity if the practitioner is negligent. The registered nurse must be aware that any policy statement made by the professional organizations or by the employing agency does not relieve him of responsibility for his own acts.

Hospitals and other health agencies employing registered nurses to care for patients in a specialized coronary care unit are urged to set up committees representative of medical, administrative, and nursing staffs and to use this statement as a guideline in developing and implementing specific policies for their own institution.

In the hospitals where it is not feasible to establish a specialized coronary care unit, the medical, administrative, and nursing staffs are urged to implement the below stated principles insofar as is possible in the care of patients with coronary heart disease.

It is believed that an effective program of coronary care within a hospital should reflect distinct aspects of patient care as identified:

(a) Coronary care concept: There is special emphasis on the physician–nurse team approach to meeting the needs of the patient through intensive surveillance, assisted by electronic monitoring, with application of immediate emergency treatment as necessary.

(b) Public health aspects: There is a knowledge of epidemiology; the emphasis on prevention of illness; and a recognition of the predisposing factors to coronary heart disease.

(c) Basic sciences: The anatomy and physiology of the cardiopulmonary system is basic to the program of care; the pathophysiology, cardiac electrophysiology, fluid and electrolyte balance; nutrition; pharmacology of cardiac drugs employed in the care of the patient; and psychosocio aspects of care.

Policies and procedures for the management of the unit must be determined jointly by the medical staff, nursing service administration, and hospital administration. They must be in writing, be readily available, and include the following:

1. Medical management for the unit, to identify and place responsibility in (on) a coronary care committee and/or a medical director.
2. Placement of medical responsibility on a specific physician for the individual patient.
3. A plan to meet patient emergencies, e. g., severe chest pain, shock, respiratory distress, multiple premature ventricular contractions, cardiac arrest.
4. A plan of nursing care which will assure continuity of care within the hospital setting and include post-hospital care and rehabilitation, utilizing appropriate community resources.
5. Staffing to be based on the ratio of one nurse to two patients.* The registered professional nurse is never to be the sole staff member on the unit, because of the constant potential of emergency and the corresponding need for assistance.
   Selected licensed trained practical nurses and nursing assistants may give supportive care *under the direct supervision* of the registered professional nurse.
6. Provision for the orderly admission, transfer, and discharge of patients to and from the unit.
7. General administrative policy to include clergy and other visitor regulations, telephone calls to patients, gifts, flowers, the handling of personal belongings.
8. Plans for delivery of services and supplies to the unit; detailed fire and safety measures; and regular expert maintenance of equipment.

The delegation of specific responsibility within this unit to the registered professional nurse must be approved by the medical staff, nursing service administration and hospital administration; it must be in writing and on file. The registered professional nurse must have special preparation for functioning in the coronary care unit, which includes planned orientation and continuing staff development.

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* USPHS publication No. 1250, Coronary Care Units, page 32.

The educational programs shall be taught by clinical nurse experts and qualified physicians and shall include instruction in:

1. Anatomy and physiology of the circulatory system.
2. Pathology of coronary heart disease.
3. Clinical signs and symptoms of myocardial infarction and diagnostic procedures used.
4. Complications that may occur such as arrhythmias, shock, acute pulmonary edema, embolism, or cardiac arrest. (It is advisable to include information on the physiologic processes involved in the above complications, such as fluid and electrolyte balance, circulation, respiration, and kidney function.)
5. Closed-chest cardiac resuscitation.
6. Electrocardiogram monitoring devices and other equipment used in the unit such as pacemakers and defibrillators.
7. Arrhythmias observed in the ECG pattern and the emergency therapeutic measures used by the physician for treatment of certain arrhythmias.
8. Medical and nursing measures used for the prevention and treatment, including drug therapy, of myocardial infarction and complications.
9. Patterns of psychological reaction and adjustment to sudden serious illness in the acute, convalescent, and rehabilitative stages.
10. Emotional support to the patient and his family throughout the stages of illness and recovery.
11. Role of family in helping patient through stages of recovery.
12. Relationship of patient energy expenditure to the physiological functioning of the heart.
13. Resources available within the hospital and community for meeting health, social and spiritual needs of patients in the acute, convalescent, and rehabilitative phases of the illness.
14. Formulation of a plan for comprehensive nursing care for the individual patient.

It is agreed that the use of cardiac monitors, defibrillators, and resuscitating equipment is a medical responsibility. However, under specific conditions, if a licensed physician is not immediately available, it becomes appropriate for the specially trained registered professional nurse, upon recognizing an emergency, to initiate treatment.

Therefore, contingent on the foregoing, the nurse may:

(a) Interpret major cardiac arrhythmias on monitor and ECG strips.
(b) Administer oxygen.
(c) Start intravenous infusions and administer intravenous medications.
(d) Increase or decrease the rate, voltage and amplitude of the transvenous demand pacemaker. He may not manipulate the cardiac catheter.
(e) Prepare for counter shock and defibrillate, in the event of ventricular fibrillation.
(f) Use equipment to assist respiration including manual breathing bag or intermittent positive pressure apparatus.
(g) Perform closed chest cardiopulmonary resuscitation.

EXCEPT IN AN ACUTE EMERGENCY, THE REGISTERED PROFESSIONAL NURSE MAY PERFORM THESE TREATMENTS ONLY UPON THE SPECIFIC ORDER OF THE LICENSED PHYSICIAN FOR THE INDIVIDUAL PATIENT.

THE REGISTERED PROFESSIONAL NURSE IS AT ALL TIMES RESPONSIBLE FOR HIS OWN ACTS. HE IS EXPECTED TO KNOW AND FUNCTION WITHIN THE LIMITS OF HIS OWN ABILITY.

Facts About Marquette . . .

• ONE OF THE STATE'S only two medical schools, both of which must be expanded according to the Governor's Task Force on Medical Education, if Wisconsin's health-care needs are to be met.

• A COMPLETELY independent and autonomous corporation which was legally separated from Marquette University in 1967 and receives no financial support from the University. It grants its own degrees and is run by a lay board of directors, one-third of whom are appointed by the Governor. The board, the 279 full-time faculty members, and the more than 400 students represent all faiths.

• AMONG 43 private medical schools in the country which are facing severe financial problems and the necessity of relying on outside sources, both private and governmental, for income; 16 of these are already receiving state aid while those in Illinois, Missouri, Minnesota, North Carolina, and Delaware are in the process of applying for state funds.

• AN INSTITUTION whose distinguished reputation attracts students and physicians from the entire country and abroad. Many of the students remain in Wisconsin to practice after graduating, and the physicians work at community hospitals in conjunction with teaching on the faculty.

• THE LARGEST single supplier of physicians to the state of Wisconsin including one-half of the physicians now practicing in Milwaukee County and one-third of those in the state.

• A TRAINING CENTER whose faculty plays a key role in the education of a total of 2,700 health-care personnel each year including nurses, dietitians, physical therapists, medical technologists, and dental students.

SMS Hot Line

A DENTIST AND A PHYSICIAN share top posts in the Council on Health, the advisory body to the Division of Health, Department of Health and Social Services. L. C. Scribner D.D.S., Stevens Point, was elected president of the Council. Ralph C. Frank, M.D., Eau Claire, was named vice-president. Dr. Frank is a former member of the Council of the State Medical Society.

WISCONSIN HOSPITAL Association and State Medical Society officers met in late July to discuss matters of mutual concern. . . . . agreed to jointly explore problems of emergency services in hospitals, including efforts to designate hospitals by "grade" of emergency service available. The two groups will also investigate improved evacuation systems for traumatic injury cases.

WISCONSIN WORK WEEK OF HEALTH plans are jelling rapidly for a five-day regional schedule in Eau Claire, Oct 6; Stevens Point, Oct. 7; Green Bay, Oct. 8; Milwaukee, Oct. 9; and Madison, Oct. 10. The Green Bay Work Week program will be shown live on TV for all schools in a 100-mile radius. Programs at each location will deal with drug use by teenagers and "Sex and the Teenager." A new feature this year will be a Community Service Award to a physician.

PURE WATER? Questions about the purity and safety of Wisconsin's public beaches and swimming pools are being raised by the Society's Commission on Health and Natural Resources. In an effort to get at the facts, all physicians will shortly be asked to report incidence of infection, illness which may be related to swimming.

RECENTLY PASSED anatomical gift act requires special interpretation for physicians and others. Example: Where total body is involved in a gift, surviving spouse or parents have certain veto rights. Not so on organ transplants. Another example: Some provisions forbid an attending physician to be part of a transplant team. SMS will undertake analysis and special report to physicians on the "ins and outs" of transplants in Wisconsin.

GRANT OF $3,000 has been made by the State Medical Society to the Charitable, Educational and Scientific Foundation to launch the George W. Hilliard, M.D. post-baccalaureate fellowship fund. Purpose: to assist worthy prospects for medical school to make up educational deficiencies which might otherwise deny them admission.

WISCONSIN BLUE SHIELD-WPS jointly shared with Radio Station WHA and WHA-TV the annual award of the Woman's Auxiliary to the American Legion for the most outstanding program for youth in 1968. Award was given to WPS for its sponsorship on radio and TV of the State Medical Society's Work Week of Health program.

APPOINTMENTS TO STATE MEDICAL EXAMINING BOARD were announced recently by Gov. Knowles. Four expiring terms were filled by the reappointments of Dr. T. W. Tormey, Jr., Madison, and Dr. H. G. Withrow (D.O.), Hustisford, and the appointments of Dr. John M. Irvin, Monroe, and Dr. A. J. Sanfelippo, Milwaukee.

NEWS HIGHLIGHTS

Dr. Leo Weinshel Is Brigadier General

Dr. Leo R. Weinshel* of Milwaukee has been promoted to Brigadier General, Medical Corps, U. S. Army Reserve. Gen. Weinshel is the Commanding General of the 801st Hospital Center, headquartered at the Lincolnwood U.S. Army Reserve Training Center, Chicago, Ill.

Dr. Weinshel

The Hospital Center is composed of 27 medical units ranging from 1000 bed general hospitals to smaller specialized detachments. Over 2200 medical personnel are assigned to the Center's command, who are located in Illinois and Wisconsin.

In civilian life Gen. Weinshel is in private practice specializing in general surgery in Milwaukee, and is active in numerous professional, civic, and community organizations. He is a member of the board of directors of Marquette School of Medicine and an associate clinical professor of surgery.

Dr. John Dettmann Elected to Area Health Council

The Northeastern Wisconsin Health Planning Council elected Dr. John Dettmann* of Green Bay as its president and adopted a set of bylaws at a meeting June 30.

Dr. W. W. Grover* of Bonduel was elected vice-president; George Curry of Green Bay, secretary; and William O'Donnell of Manitowoc, treasurer.

The council, which includes Brown, Door, Kewaunee, Menominee, Shawano, and Sheboygan counties, will consist of a maximum of five representatives from each participating county according to the new bylaws.

The council is in the process of applying for a two-year federal planning grant under the Partnership for Health Act of 1966. It sponsored a health planning seminar July 17 at the University of Wisconsin–Green Bay.

Wis. Pathologists to Meet

The fall meeting of the Wisconsin Society of Pathologists will be held in Madison Nov. 22 at St. Mary's Hospital. The program, from 10 a.m. to 4 p.m., will be Forensic Pathology.

Catalog of Health–Sciences Available from Med. Library

A list of periodicals held by 18 health–science libraries in the Madison area has been completed by the Madison Health–Sciences Information Personnel Group. The list will serve as a guide to hospital, clinic, and smaller departmental libraries, as well as the parts of larger public library collections which relate to health and life sciences.

The holdings of the University of Wisconsin Middleton Medical Library have not been included. The list expands the reference sources which Medical Library users may require and provides direct communication between the Madison area libraries and the Medical Library.

Copies of the UNION CATALOG can be obtained for $2.00 by writing Mrs. Frances Gale, Secretary, William S. Middleton Medical Library, 1305 Linden Drive, or by calling (608) 262–6594, Madison, Wis. 53706.

Wis. Orthopedists to Meet

The Wisconsin Orthopaedic Society will meet Sept. 19–20 for its fall meeting at Lake Delton.

PHYSICIAN BRIEFS

Dr. E. M. Schmidt*

. . . Berlin, recently closed his office after practicing in the Berlin–Redgranite area for the past eight years. He will be engaged in the field of public health and pharmaceutical research in Wisconsin.

Dr. Jerome S. Mayersak

. . . Wisconsin Rapids, recently became associated with the Medical Arts Group in Wisconsin Rapids. Doctor Mayersak graduated from George Washington University School of Medicine and completed his internship and residency work at the George Washington University Hospital. He served as senior resident physician in urology at the District of Columbia Hospital in 1967 and the Veterans Administration Hospital, Washington, during 1968. He also served an assistantship in surgery at George Washington University for four years.

Dr. Parnell Donahue

. . . Hales Corners, became associated in practice with Drs. John J. Czajka and John F. Alstadt.* Doctor Donahue graduated from the Marquette School of Medicine and served his internship at St. Joseph's Hospital and residency work at Milwaukee Children's Hospital.

Dr. M. R. Khavari

. . . Eau Claire, former gynecologist with the maternal and child health project of the Chicago board of health, recently joined Dr. E. F. Hill.* Doctor Khavari graduated from the Tehran University School of Medicine and served his internship and residency in Tehran.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dr. Metodio Reyes

. . . Arcadia, recently joined the practice of Dr. Servando Pesarillo* at the Arcadia Medical Center. He has been a staff physician at the VA Hospital, Tomah, for the past 15 months. He is a native of Ibaan, Batangas, the Philippines, and received his medical degree from the University of Santo Tomas, Manila.

Dr. E. J. Sullivan

. . . Fond du Lac, joined the pathology department at St. Agnes Hospital. He is a graduate of the Marquette University School of Medicine. Doctor Sullivan interned at St. Joseph's Hospital, Marshfield and served a residency in pathology at South Bend, Ind., Medical Foundation. He has been on the medical staff at Memorial Hospital in Johnson City, Tenn., for the last nine years.

Dr. Raymond J. Rogers*

. . . Oconto, founder and director of the U. P. Cytology Laboratory in Menominee, recently semi-retired. Doctor Rogers established the laboratory in 1950; it will continue to operate under his supervision.

Dr. Sidney Shindell*

. . . of Milwaukee is the author of a major article entitled "Legal Aspects of Community Health Activities" in the June 30 issue of MODERN MEDICINE. The article is one of eight in a special "Symposium on Medicolegal Problems," covering significant legal aspects of medicine. Doctor Shindell, an MD and bachelor of laws, is professor and chairman of the Division of Preventive Medicine, Marquette School of Medicine. He is a 1946 graduate of State University of New York Downstate Medical Center, Brooklyn.

Dr. G. A. Landman*

. . . is now located in new medical offices in Tomah. He formerly was associated with Dr. J. S. Mubarak* at the Tomah Clinic.

Internists to Meet in Sept., Lake Delton

The president of the American Society of Internal Medicine and the immediate past president of the American College of Physicians will headline the program of the Wisconsin Society of Internal Medicine Sept. 12 and 13 at Kahler's Inn Towne, Lake Delton. Both national organizations are cooperating in presenting the WSIM annual meeting.

Dr. Clyde C. Green, Jr., San Francisco, Calif., president of ASIM, will speak at the annual business meeting of WSIM Friday noon, Sept. 12.

Dr. M. Marvin Pollard, Ann Arbor, Mich., of the ACP, will speak at the breakfast meeting of the College Saturday morning at 8:30.

The Friday scientific program will be a symposium on liver diseases. The Friday afternoon Middleton lectureship will be given by Doctor Pollard. His topic will be "Current Problems in Medical Education." The Friday afternoon socio-economic topic will be "Computers in Medicine."

The Saturday schedule will include a morning-long symposium on infectious diseases.

The WSIM All-Event Golf Tournament will precede the convention on Thursday, Sept. 11, at the Delview Golf Course. Wives also are invited to participate.

Social functions and women's activities will repeat the popular annual meeting activity of three years ago and will feature the Dells' River Boat trip in place of the annual banquet Friday evening.

There will be a women's brunch at 10 a.m. on Friday morning and there will be a special information desk for women to coordinate activities of interest.

Details of the scientific program will be found in the MEETINGS section of this issue.

Better Emergency Care for Hwy. Crash Victims

Improved inhospital emergency treatment of highway crash victims is the aim of a new educational program to be launched by the American College of Surgeons with financial assistance from the Insurance Institute for Highway Safety.

Dr. William Haddon, Jr., Institute president, announced recently that a $15,000 grant had been made to enable the College's Committee on Trauma to undertake the program. The College is matching this amount and also will seek additional funding to expand the program.

The new program will be under the staff direction of Dr. Oscar P. Hampton, assistant director of the College for trauma activities.

St. Francis Hospital, La Crosse, Expanding

Plans for a new $1,800,000 Rehabilitation Center addition to St. Francis Hospital in La Crosse were announced recently by Sister Mary Gregory, hospital administrator.

The new, four-story structure will provide facilities for complete rehabilitation services, including physical therapy, occupational therapy, occupational and recreational therapy, speech and music therapy, and social service counseling. General and special services for private and group therapy will be provided.

Bids are expected to be let in late fall with construction to begin in early 1970.

RESIDENT-INTERN PAPERS PROGRAM

1969 Annual Meeting State Medical Society

May 12–15, Milwaukee

Winners

MIDDLETON AWARD: $100
to
Dr. Donald H. Reigel, Resident in Neurosurgery, VA Hospital, Wood

Cerebral Inhibition of Gastric Resection

BECKMAN AWARD: $100
to
Dr. Gordon D. Murley, Resident in Surgery, Marquette School of Medicine, Milwaukee

Effect of Phosphate Infusion on Gastric Resection

View Expansion, Health Planning Council

Comprehensive health planning in the Madison and Dane County area may expand into 10 other counties that are considering the possibilities of joining the Health Planning Council, Inc.

Under state regulations, each county in the state must be in such a council. And the state is being divided into nine areas, according to Dr. George Handy,* executive director of the Bureau of Comprehensive Health Planning of the State Division of Health.

County resource committees have been set up in Sauk, Columbia, Green, Iowa, LaFayette, Richland, Grant, and Dodge counties to consider the affiliation with the group. Rock and Jefferson counties are starting consideration.

Comprehensive health planning programs are part of a new method of distributing federal health funds, which started in 1966 with Congress passing the Partnership for Health law.

The program allows local communities to review and make recommendations for spending federal health funds in their areas.

BOOKLET DESCRIBES VIRUS–CANCER STUDIES

Studies of the role viruses play in cancer causation are described in a 20-page booklet, "Virus–Cancer Research," issued for the general public by the U. S. Department of Health, Education, and Welfare. It was prepared by the National Cancer Institute, National Institutes of Health, as a general revision of an earlier booklet by the same title.

Single copies of the pamphlet (NIH Publication No. 29) are available without charge from the U. S. Department of HEW, Washington, D.C. 20402. It may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D.C. 20402 at 20 cents per copy.

Dr. Lloyd Williams*

. . . an Appleton pediatrician, and Dr. William Boake, internist at University Hospitals, Madison, examined 18 referral patients at a congenital rheumatic heart clinic for Door and Kewaunee counties in June at Sturgeon Bay. The clinic was conducted under auspices of the Wisconsin Heart Association.

Dr. Patricia Lanier*

. . . of Kewaunee in June was named first vice-president of the American Association of University Women, the first woman from Wisconsin to be elected to a national AAUW office since World War II. This month (August) she is representing the more than 175,000 women members of the AAUW at an international meeting in Stockholm, Sweden. She is one of 53 representatives from as many countries at this International Federation of University Women council meeting.

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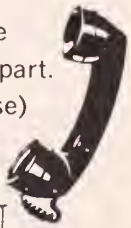

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Dr. Frederic E. Mohs*

. . . of Madison is one of six U. S. physicians whose comments on treatment of head and facial skin cancers are included in the June 30 issue of MODERN MEDICINE. The comments appear in the "Forum" section of the medical journal. Doctor Mohs, a general surgeon, maintains a private practice in Madison and also serves in the Chemosurgery Clinic of University Hospitals. He graduated from the University of Wisconsin Medical School in 1934.

Dr. Jose Q. Tolentino

. . . in early July arrived in Adell to begin a medical practice in a community that has been without medical care since the deaths of Dr. Frank Naylen and Dr. Ira Bemis. Doctor Tolentino, who comes from a small village in the Philippine Islands, was interning in Milwaukee when he learned of the Adell plight to obtain the services of a physician. Doctor Tolentino's wife is a dietician and she is assisting him as secretary and receptionist.

Dr. Anno P. Patel

. . . Marshfield, recently joined the medical staff of the Marshfield Clinic. He received his medical degree from the University of Bombay and interned at hospitals in Liverpool and Manchester, England. Doctor Patel specialized in orthopedic surgery as a fellow in the Royal College of Surgeons in Edinburgh, Scotland, and was on the staff of the University of Manitoba, Winnipeg, Canada, before coming to Marshfield.

Dr. Alexander A. Hegedus

. . . has joined the staff of the Pember–Nuzum Clinic in the department of internal medicine. He came to Janesville from Balboa Heights, Panama, after serving his internship and completing a three-year residency in internal medicine at Gorgas Hospital. He started undergraduate studies in Hungary, entered the U.S. in 1956, and became a citizen of this country in 1965. □

Patients Like Computers, Study Shows

Patients at University of Wisconsin Hospitals enjoy giving their medical histories to a computer and some speak more freely to the machine than to a physician.

These findings come from a Wisconsin study evaluating LINC (Laboratory Instrument Computer), which has been taking such histories at University Hospitals since 1966.

As use of LINC continued, Dr. Warner V. Slack and Lawrence J. Van Cura of the departments of medicine and computer sciences became concerned that patients would resent LINC for taking over a role traditionally assigned to the physician.

But results of their study of 275 patients interviewed by LINC show little reason for concern.

"Patients established a rapport with the machine quickly, had words of praise for it during the interview, and genuinely enjoyed themselves," Dr. Slack explains.

The computer program follows a meticulous logic, beginning with a general question such as "Have you ever been bothered by chest pain?" The patient can answer "yes," "no," "don't know," or "don't understand" to each question by punching keys on the computer.

If the patient answers "no," the next general question flashes on the computer screen. If he answers "yes," the computer asks further questions that trace the source of the pain.

A "don't know" or "don't understand" answer leads to clarifying questions.

At the conclusion of each of the 275 interviews, patients could evaluate the experience by making one of four answers to questions such as "Did you find this interview difficult?", "Did you enjoy it?", and "Do you prefer being interviewed by this method or by a physician?"

The patients' answers demonstrated their delight with the computer, the Wisconsin researchers say.

The computer was deemed more thorough when taking general medical histories, but specialty interviews such as those required for allergy and gynecology patients are more detailed when recorded by a physician, they found.

Gynecology patients, however, routinely prefer LINC as an asker of questions of a personal nature. "Information which the patient has difficulty telling but wants the doctor to know about is more easily presented and more likely to be given accurately to the computer," Dr. Slack adds.

With the prospect of expanding computer interviews to other professions such as law, Slack and Van Cura feel there is little cause for worry about antagonism between client and computer.

UW Hospitals Issues Medical Staff Directory

Physicians throughout Wisconsin recently received comprehensive directories listing the active medical staff of University of Wisconsin Hospitals, Madison.

Physicians considering referral of patients to UW Hospitals can now use the updated directory to call and confer directly with staff physicians in the desired specialties.

The 5,850 directories were made available through the assistant superintendent's office of UWH. Those not receiving the 6"x9" directory and wishing extra copies may obtain them by writing to Martin Albrecht, assistant to the Superintendent, University Hospitals, 1300 University Avenue, Madison 53706.

It is hoped that the revised edition will speed the referral process to give more personalized and efficient care to patients throughout the state.

Wis. Surgeons to Austria

The Wisconsin Surgical Society will hold its fall meeting Sept. 16–23 at Innsbruck, Austria.

The scientific program will include noted European physicians as well as members of the Wisconsin Surgical Society.

Details of the program appear in the Medical Meetings section of this issue.

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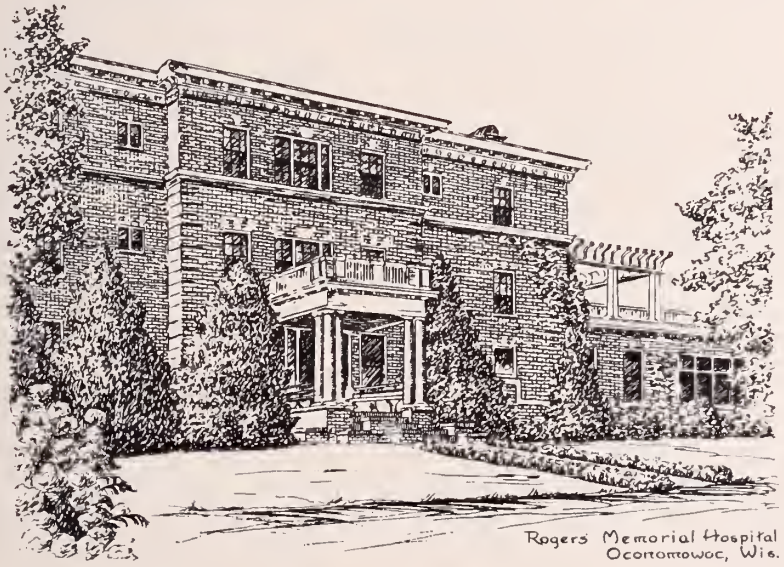

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JOHN J. O'HARA, M. D.
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Co. Society Urges Merger, Wausau Hosp.

The Marathon County Medical Society has recommended to the Wausau Area Health Facilities Planning Council that Wausau's two general hospitals, Wausau Memorial and St. Mary's, operate "under one merged board as soon as possible."

This announcement was made in June along with six other important resolutions dealing with the future of health services in the Wausau community.

In the other resolutions, all adopted at the May meeting of the Marathon County Medical Society, the Society:

. . . Reaffirms its opposition to construction of another hospital for care of patients with short-term mental illness, but the physicians' group "continues to recommend support of proper care for the long-term mentally ill by the county."

. . . Recommends that a comprehensive community survey be done by an outside firm to guide community members in the development of our community health services and that this be performed as soon as feasible.

. . . Recommends that pending a merger of the two hospitals the obstetric and pediatric services be combined and that the medical and surgical cardiovascular services be combined.

. . . Recommends that the obstetric and pediatric unit be consolidated at Wausau Memorial Hospital now.

. . . Recommends that the complete medical and surgical cardiovascular unit be at St. Mary's Hospital now.

. . . Recommends that the income and expenses of any consolidated unit be divided by both hospitals until such time that the hospitals can be merged.

In presenting the resolutions to the Health Facilities Planning Council, Dr. A. W. Hoessel,* president of the Marathon County Medical Society, noted that the Society also reaffirmed its support for a strong Health Facilities Planning Council.

Adoption of the resolutions by the Medical Society followed a report by Dr. W. T. Becker,* chairman of the Society's hospital planning committee.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JULY 1969

1 Dane County Medical Society Board of Trustees
3 SMS Commission on Health and Natural Resources
7 Dane County Medical Society Utilization Review Plan
8 Board of Directors, Wisconsin Association of Professions
9 SMS Commission on Health Information
14 Committee on Drug Dependency, State Dept. of Health and Social Services
14 Dane County Medical Society Insurance Advisory Committee
17 Editorial Subcommittee, SMS Division on School Health
22 Professional Nurse Registration Examination
23 Professional Nurse Registration Examination
23 SMS Committee on Occupational Health
23 SMS Division on Alcoholism and Addiction
24 Professional Nurse Registration Examination
24 Executive Committee, WPS Charge Card Corporation
24 Executive Committee of SMS Commission on Medical Care Plans
24 Wisconsin Regional Medical Program Staff
25 Professional Nurse Registration Examination
25 Advisory Committee on Utilization Review Programs
28 State Pharmacy Board Examination
30 Board of Trustees, SMS Realty Corporation
31 Executive Committee of SMS Council with Executive Committee of Wisconsin Hospital Association (Waukesha)

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Organizational Efforts for NW Wisconsin CHP Are Progressing

The Northwest Wisconsin Comprehensive Health Planning Council was recognized in June as Dunn County's agent in developing an areawide comprehensive health planning program.

Dunn County is the sixth county to recognize the agency which tentatively anticipates encompassing 11 counties: Polk, Barron, Rusk, St. Croix, Dunn, Chippewa, Pierce, Pepin, Eau Claire, Buffalo, and Jackson.

Dr. A. A. Drescher,* Menomonie, is one of the representatives for Dunn County.

Dr. Eugene Kleinpell, River Falls, and Dr. Ralph C. Frank,* Eau Claire, are members of the council's steering committee which is handling program developments.

Psychiatric Residency Program Approved for Winnebago State Hospital

Winnebago State Hospital has added a one-year psychiatric residency to its educational program and two of the four doctors approved for the new program took residence July 1.

Dr. George Lysloff, assistant clinical director, heads the hospital's research and education program. He indicated that the long-sought program is approved by the Council on Medical Education of the American Medical Association.

The first two psychiatric residents at Winnebago State Hospital are Dr. Arthur Brenner, a New York resident and graduate of the University of Vienna, and Dr. Paul Derboven of Brussels, Belgium. A third resident, expected soon, is Dr. Hermann Pecher, Germany.

Dr. Guardalabene Remembered

In memory of Dr. Vito Guardalabene, a prominent general practitioner in Milwaukee who died in September 1968, Milwaukee Ladies of Unico, a civic organization, donated a $3,000 kidney machine to St. Michael's Hospital in Milwaukee.

In giving the machine the women said that it was in memory "of one of Milwaukee's Italian–Americans who practiced life-saving not only with today's modern machines but also with that God-given machine called a heart."

MRS. JAMES W. SARGENT, MILWAUKEE . . .

Named Committee Chrm., AMA Auxiliary

Mrs. James W. Sargent of Milwaukee was named community health chairman of the Woman's Auxiliary to the American Medical Association during the Auxiliary's 46th annual convention July 13–17 in New York City.

As community health chairman, Mrs. Sargent will encourage the state and local auxiliaries to select and promote educational and service activities relating to health and medical care in both urban and rural communities.

Mrs. James Sargent

She is immediate past president of the Woman's Auxiliary to the State Medical Society of Wisconsin and served as its community service chairman from 1960–1962.

In addition to serving on committees for the American Association of University Women, Mrs. Sargent is active in two Milwaukee hospital auxiliaries.

Mrs. Sargent received her BA and MA degrees from the University of Michigan.

SK&F Services Catalog Released

Smith Kline & French Laboratories has just released its *SK&F Services Catalog 69/70*. This new edition offers 50 pages of SK&F services, available to physicians without charge.

Included in the illustrated Catalog are medical films, booklets, periodicals, Speakers Bureau, and the "Code 4" cardiopulmonary resuscitation training program.

The Services Catalog is revised and published yearly by Smith Kline & French as a part of the company's program to provide the medical profession with a wide range of useful services.

A free copy may be obtained by contacting the SK&F representative, or by writing to the Services Department E-10, Smith Kline & French Laboratories, 1500 Spring Garden, Street, Philadelphia, Pa. 19101.

CALEB FISKE MEDICAL ESSAY COMPETITION ANNOUNCED

The Trustees of America's oldest medical essay competition, the Caleb Fiske Prize Essay of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Medical Education In The Years Ahead." The essay must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $500 is offered. Essays must be submitted by Dec. 15, 1969.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence, R. I. 02903.

Medical Museum Helps Boy Scout Program

Boy Scout troops in Wisconsin are being given "free admission" to the Museum of Medical Progress in Prairie du Chien.

"To honor the concept of 'Boypower '76,' the new Scouting program, the Museum in July declared an 'open admission' policy to all Scout troops in this State who are accompanied by a registered Scouter," said Dr. William Stovall* of Madison.

Doctor Stovall is president of the Society's Charitable, Educational and Scientific Foundation, the unit which owns and operates the Museum.

Earlier this year the Boy Scouts of America launched the "Boypower '76" program which will end in 1976, the 200th anniversary of the Declaration of Independence. Nationally, 25% of all boys at the scouting age belong to the movement. The objective of "Boypower '76" is to raise that figure to 33%, making greater gains especially in the core areas of the United States.

"This vibrant new Scouting program can make a key contribution to our leaders of tomorrow," said Doctor Stovall, "and the physicians of Wisconsin, through our Foundation, welcome the opportunity to give a little recognition to such a sound youth project."

The Museum of Medical Progress is a registered national landmark. Part of the complex is the restored Military Hospital of Old Fort Crawford. The Fort dates back to 1829, the period of Indian uprisings along the Northwest Frontier.

The Museum is open daily from 9:00 a.m. to 5:00 p.m. through October 31. From July 4 through Labor Day it is also open evenings until 9:00 p.m. Normally, admission is 50 cents for adults (and teenagers, hence Boy Scouts) and 15 cents for children.

Officers Reelected to Society's CMCP

At a recent meeting of the State Medical Society's Commission on Medical Care Plans—the governing board for the Society's insurance division, Wisconsin Blue Shield—three members were reelected as officers: Dr. John T. Sprague,* Madison, treasurer; Dr. Robert A. Sievert,* Madison, assistant treasurer; and Dr. Robert Krohn,* Black River Falls, vice-chairman.

Dr. D. N. Goldstein,* Kenosha, and Dr. W. T. Casper,* Milwaukee, were reelected as delegates to the National Association of Blue Shield Plans.

Chairman of the Commission is Dr. E. M. Dessloch,* Prairie du Chien.

CONTRIBUTIONS—CES FOUNDATION

June 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for June 1969:

Nonrestricted

H. Kent Tenney, MD	Contribution
Sylvia Graf Foundation Inc.	Contribution
State Medical Society	Voluntary contributions of 17 MDs
Dr. and Mrs. Walter H. Jaeschke	Memorial: C. W. Aageson, MD
Alma O. Walsh	Memorial: C. W. Aageson, MD
Ethel M. Kohn	Memorial: C. W. Aageson, MD
Jerry Henry	Memorial: C. W. Aageson, MD
Dr. and Mrs. Fred W. Kundert	Memorial: C. W. Aageson, MD
Mr. and Mrs. L. E. Cook	Memorial: C. W. Aageson, MD
Mr. and Mrs. Ray Kelly	Memorial: C. W. Aageson, MD
Mrs. Jene Hammill	Memorial: C. W. Aageson, MD
Dane County Medical Society	Memorial: C. W. Aageson, MD
Mr. and Mrs. Earl R. Thayer	In honor of: Dr. and Mrs. H. Kent Tenney
Mr. and Mrs. Earl R. Thayer	In honor of: Dr. and Mrs. Horace K. Tenney, III
Margaret K. Pharo	Memorial: Mrs. Chas. Pollack
Vera Meyer	Memorial: Mrs. Chas. Pollack

Museum of Medical Progress

State Medical Society	Voluntary contribution of 1 MD
County of Crawford—State of Wisconsin	Contribution

Student Loans

State Medical Society	Voluntary contributions of 2 MDs
Woman's Auxiliary to the State Medical Society	Contribution
Gustave E. Eck, MD	Contribution

Tormey Memorial Fund

Mr. and Mrs. J. G. Werner	Memorial: Mr. Leo J. Blied
Mr. and Mrs. J. G. Werner	Memorial: C. W. Aageson, MD
Mr. and Mrs. J. G. Werner	Memorial: Mrs. Amanda Sonnenberg

History of Nursing in Wisconsin Exhibit

Lederle Laboratories	Contribution
Hellwig, Inc.	Contribution

Danforth Student Loan Fund

Mrs. Quincy H. Danforth	Contribution

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

G. W. Hilliard, Jr., MD—Fellowship Fund

Peter L. Eichman, MD	Memorial: G. W. Hilliard, Jr., MD

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorial: Mrs. Chas. Pollack
C. H. Crownhart	Memorial: Ralph P. Sproule, MD

Wisconsin Society of Pathologists—Historical Exhibits

Mayfair Pathology Association	Contribution
Consultant Physicians in Pathology	In honor of: Robert A. Scheidt, MD

WPS–Blue Shield and WHA Share Legion Aux. Award

Wisconsin Physicians Service—Blue Shield and WHA, the University of Wisconsin radio station, were presented the 1968–69 "Radio Local Station Award" by the American Legion Auxiliary of Wisconsin for the best program series "in the interest of youth."

The presentation was made July 19 during the Auxiliary state convention in Cooley Auditorium, Milwaukee Technical College.

The co-recipients received the award for a taped radio series based on "Youth On A Four-Day Trip," a health conference for Wisconsin teenagers that was sponsored by the State Medical Society of Wisconsin Oct. 1–4, 1968, in Madison.

"Youth On A Four-Day Trip" was the subject of the Society's Sixth Annual Work Week of Health. It drew an audience of about 3,500 youngsters from every corner in the state.

During "Youth," WHA radio taped such discussions as, "Should You Keep Off (Or On) the Grass (marijuana)," "Sex and the Teenager" and "LSD and Other Many Splendored Things."

Wisconsin Physicians Service—Blue Shield, a division of the State Medical Society, made a grant to WHA for the documentary series. The tapes were broadcast over the state radio network and are currently available from the Society on loan.

On hand to receive the award were Dr. William D. James,* Oconomowoc, immediate past president of the Society, and Ralph W. Johnson of WHA. Doctor James, then Society president, was the official host of "Youth On A Four-Day Trip."

The American Legion Auxiliary has submitted the series to its national organization for a national awards entry.

THE PRESIDENT'S RECEPTION for Dr. Robert E. Callan of Milwaukee, who took office in May as president of the State Medical Society of Wisconsin, was held at Society headquarters June 15. More than 200 colleagues, relatives, and distinguished citizens of the state attended. Doctor Callan is shown above in the center. Others in the reception line, at the left, are Dr. Jerry W. McRoberts, president-elect, Sheboygan; Mrs. Callan; and at the right, Mrs. William D. James and Doctor James, immediate past president, Oconomowoc. The two guests are Phyllis Schirmer, president of the Wisconsin State Medical Assistants Society, and June Gillette, speaker of the WSMAS House of Delegates. Others in the receiving line, not shown, were Dr. and Mrs. Eugene J. Nordby, chairman of the Council, Madison; and Mrs. McRoberts.

Explains New Heart Repair Surgery

A major concept in the care of a heart patient was advanced recently when Dr. Derward Lepley, Jr.* of Milwaukee presented his views to members of the Wisconsin Heart Association meeting in Milwaukee in June.

During a panel discussion on heart transplantation, Doctor Lepley stated that in many instances a Wisconsin-perfected technique of heart reconstruction may do the job more satisfactorily than a transplant.

Doctor Lepley, who is president-elect of the WHA and headed a team which performed the first heart transplant in Wisconsin, reported on a procedure of heart operations in Milwaukee by a team of cardiac surgeons and cardiologists, headed by Dr. W. Dudley Johnson.*

The Milwaukee team has performed the procedure on 301 patients in the past three years in three Milwaukee hospitals, Doctor Lepley declared.

The Milwaukee "alternative" to a new heart involves salvaging the "old" heart through transplantation of veins and arteries so that a supply of blood is brought to the heart from areas of the body not affected by heart disease.

OB–GYN Group to Meet

Members of the Wisconsin Society of Obstetrics and Gynecology will meet Sept. 20 at Bailey's Harbor in Door County.

Officers of the Society are: Dr. Samuel G. Perlson,* president; Dr. Elizabeth A. Steffen,* vice-president and president-elect; and Dr. Herbert F. Sandmire,* secretary-treasurer.

Radiologists to Meet

Dr. David M. Witten of the Mayo Clinic, Rochester, Minn., will be guest speaker of the Wisconsin Radiological Society when it meets Sept. 19–21 at The Abbey, Fontana.

Dr. Wayne Rounds* of Madison will take office as president at this 20th annual meeting, with other officers to be elected at the same time.

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Congenital Heart Anomalies . . .

The next meeting of the Milwaukee Academy of Medicine will be held Oct. 21 at the University Club of Milwaukee with Dr. Jesse E. Edwards speaking on congenital heart anomalies in the adult. Reservations to: 561 North 15th Street, Milwaukee; tel. (414) 342–7714. □

American Medical Writers in Membership Campaign

The American Medical Writers Association has started a "Writer-to-Writer Membership Campaign" in the hopes of doubling its membership during 1969.

The AMWA is an international society whose members are engaged in all aspects of communication in medicine, its allied professions and sciences. Founded in 1940 with a membership of 27, AMWA was incorporated as a nonprofit educational organization in 1951, and became affiliated with the American Association for the Advancement of Science in 1952.

Today, with a membership in the thousands, AMWA is the largest association dedicated to the advancement and improvement of biological and medical communication.

In the present era of intricate scientific discoveries, the medical writer's task and responsibility constantly grow not only in the scientific area, but in the ethical objectives, therefore, is to offer guidance in the art and techniques of medical communication, and to develop courses and workshops for these purposes.

Membership application may be obtained from the National Office: 420 Lexington Ave., Suite 417, New York, N.Y. 10017; tel. 212/683–6066.

—KEITH W. SEHNERT, M.D.
Chairman, Membership Committee

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Dr. Burns

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Dr. Muehlhaus

ANNUALLY THE State Medical Society of Wisconsin pays its respect to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity.

Included below are the names, pictures, and short biographical data of those physicians honored by the Councilors, Officers, and Past Presidents of the Society at the 128th annual meeting of the State Medical Society, held in Milwaukee, May 12–15, 1969.

ROBERT E. BURNS, M.D., Madison

Born May 6, 1895 in Wisconsin Rapids, Wis. Attended University of Wisconsin, University of Pennsylvania. Received M.D. degree from University of Pennsylvania in 1919. Graduated cum laude. Orthopaedic surgery practice. Member of Dane County Medical Society, The State Medical Society of Wisconsin, American Medical Association, Clinical Orthopaedic Society (past president), American Academy of Orthopaedic Surgeons, American Orthopaedic Association, Wisconsin Orthopaedic Society (past president), International Society of Orthopaedic Surgery and Traumatology, American Fracture Association. Fellow, American College of Surgeons. Received his specialty training at the Hospital for the Ruptured and Crippled, New York, and at the Mayo Clinic and is a member of the alumni associations of both institutions. Served at the University of Wisconsin Medical School as instructor, assistant and associate professor, 1923–30, and Professor of Orthopaedic Surgery, 1930, until retirement in 1962. In 1968 he was honored by the Wisconsin Alumni Association with the Emeritus Professor award of the year. Married Doctor Charlotte Calvert, Sept. 16, 1930. Children: Thomas Calvert, Doctor Charlotte A., Mrs. Richard P. (Mary Ellen) Gibbs.

EDGAR J. CRAITE, M.D., Lake Tomahawk

Born Dec. 29, 1894 in Rice Lake, Wis. Attended grade school in Rice Lake and high school at St. Thomas, St. Paul, Minn. Attended Marquette University School of Medicine. Practiced medicine and surgery in Rice Lake for two years, then went to Milwaukee as medical director of Johnston Emergency Hospital. Appointed district court psychiatrist and held that position for 15 years, and during that time also had a private practice. Member of the surgical staff of Johnston Emergency Hospital for 25 years. Member of The Medical Society of Milwaukee County, The State Medical Society of Wisconsin and The American Medical Association. Wife: Margaret J. Children: Joanne M. (deceased), John R.

JOHN R. DUNDON, M.D., Milwaukee

Born July 26, 1893 in Ishpeming, Mich. Attended Rush Medical College of the University of Chicago. Received M.D. in 1919. General practice. Member of The Medical Society of Milwaukee County, The State Medical Society of Wisconsin, American Medical Association, Milwaukee Academy of Medicine, Catholic Physicians Guild, Wisconsin Academy of General Practice. Active in numerous civic and fraternal groups. Sports enthusiast. Served in World War I and U.S. Reserve Corps. Wife: Loretta. Children: Sister Marie Louise, S.S.N.D., Rev. Thomas R., S.J., Ph.D., Mrs. Elizabeth Gaffney, Mrs. Monica Olsen, Rev. Stanislaus, O.C.D., Mrs. Frances DuPont, Peter, James, Jane.

MARIAN LEWIS, M.D., Milwaukee

Born Oct. 14, 1890 in Milwaukee, Wis. Attended Rush Medical College of the University of Chicago. Received M.D. degree in 1918. Member of The Medical Society of Milwaukee County, The State Medical Society of Wisconsin, American Medical Association, Milwaukee Academy of Medicine, American Thoracic Society. "After graduation from Rush Medical College and serving an internship at Cook County Hospital, I returned to Milwaukee and began practice in association with my father, Doctor Clinton Huntington Lewis. The flu epidemic of 1919 kept both of us very busy. Our working together continued happily until January 1929 when my father died. I carried on alone and later limited my activity to the Milwaukee Health Department—first as part-time school physician and later as clinic physician at the Tuberculosis Control Center. Health problems forced my semi-retirement in 1957 but I was able to spend 11 years assisting gynecologist Doctor Alice Watts."

MARRIOTT T. MORRISON, M.D., Mt. Horeb

Born Jan. 26, 1895 in St. Louis, Mo. Attended Washington University School of Medicine. Received M.D. degree June 12, 1919. General practice. Member of Dane County Medical Society, The State Medical Society of Wisconsin (former delegate), American Medical Association, American Academy of General Practice since 1947, now a life member. Former member of St. Louis Medical Society and St. Louis County Medical Society. Chief of admissions and personnel physician, VA Hospital, Madison, Wis. Wife: Phelleda B. Children: William M., Mrs. Donald O. Dennis.

FRANZ R. MUEHLHAUS, M.D., Milwaukee

Born April 1, 1893 in Germany. Attended Universities of Leipzig and Munich. Received M.D. degree Oct. 18, 1919. General practice. Member of The Medical Society of Milwaukee County, The State Medical Society of Wisconsin, American Medical Association. Wife: Mary. Daughter: Rea.

FRED S. SELLE, M.D., New Berlin

Born Feb. 6, 1893 at Lake Crystal, Wis. Attended University of Minnesota and Marquette University. Received M.D. degree in 1919. General practice. Member of The Medical Society of Milwaukee County, The State Medical Society of Wisconsin, American Medical Association. Citation (self proclaimed): "Who 30 years ago had enough fortitude and FEAR to discontinue the use of cigarettes." Veteran of World War I. Wife: Mary. Children: Mrs. William (Patricia) Ivens, Mrs. Vincent (Marion) Strawbridge, Mrs. William (Lois) Jones.

Dr. Selle

Dr. Sproule

Dr. Squier

Dr. Stang

Dr. Tenney

Dr. Welke

RALPH P. SPROULE, M.D., Milwaukee†

Born May 29, 1894 in Milwaukee, Wis. Attended Northwestern University and received M.D. degree June 18, 1919. Specializes in eye, ear, nose & throat. Past president—Wisconsin State Medical Society, Milw. County Medical Society & Milwaukee Academy of Medicine. Fellow in American Laryngological, Rhinological, and Otological Society & International College of Surgeons. Life member of Milwaukee Academy of Medicine. Member of Wis. State Med. Society, Milw., County Med. Society, American Medical Assoc., Milw. Academy of Medicine, Chicago Otolaryngological, Rhinological & Otological Society, American Academy of Ophthalmology & Otolaryngology, Wisconsin Otolaryngological Soc. Pan American Assn. of Ophthalmology. Member of Rotary, P. A. C. E., Press Club, 32nd degree Mason; Director of Milwaukee Boys Club & Legal Aid Society. Wife: Ilse. Children: John Sproule, Mrs. Winston (Phoebe) Markey, and Dr. Ralph T. Sproule.

† Deceased (June 27, 1969)

THEODORE L. SQUIER, M.D., Milwaukee

Born Aug. 21, 1893 in Battle Creek, Mich. Attended University of Michigan Medical School. Received M.D. degree in 1919. Internal medicine, allergy practice. Fellow, American College of Physicians; Fellow, American Academy of Allergy (secretary 1946–48, president 1951); Fellow, American Association for Advancement of Science; Non-resident Fellow, Chicago Institute of Medicine. Member of Central Society for Clinical Research, The Endocrine Society, Milwaukee Academy of Medicine (secretary 1934–41, president 1943), Wisconsin Heart Club, Milwaukee Society of Internal Medicine, Chicago Society of Allergy (president 1941), New York Academy of Sciences, Wisconsin Academy of Arts, Science, Letters, Wisconsin Society of Internal Medicine, The State Medical Society of Wisconsin, The Medical Society of Milwaukee County, American Medical Association, American Board of Internal Medicine, American Sub-Board of Allergy, NIH Training Grant Committee 1957–60. Area consultant Veterans Administration (Ft. Snelling area). Honorary member of Academia Medica de Roma, Italy. Clinical Professor of Medicine Emeritus, Marquette School of Medicine. On staffs of Milwaukee County General Hospital, Milwaukee Children's Hospital and Columbia Hospital. Wife: Nina Amelie (La Barge). Children: Theodore, Jr., John David, Charles L.

H. M. STANG, M.D., Hayward

Born March 2, 1888 in Eau Claire, Wis. Attended University of Wisconsin and Harvard Medical College. Received M.D. degree in 1919. Urology and general practice. Member of The State Medical Society of Wisconsin, American Medical Association, American College of Surgeons, American Urological Association, American Board of Urology, Eau Claire–Dunn–Pepin County Medical Society (past president, secretary, treasurer), State Medical Society's 10th Councilor District Medical Society of Wisconsin (past president, secretary, treasurer), former Councilor of State Medical Society, Wisconsin Urological Society (a founder of Society and past president, secretary, treasurer), Twin City Urological Society (past president, secretary), North Central Section American Urological Society (past president, secretary, treasurer), Executive Council of the American Urological Society, preceptor of University of Wisconsin Medical School, president of Medical Staff of Lutheran Hospital, Eau Claire, Wis., member of Sacred Heart Hospital medical staff, Eau Claire, president of Luther Hospital Training School Committee for two years and instructor for 17 years, member of Alumni Board of University of Wisconsin for one term. Founder and associate of Midelfort Clinic, Eau Claire. Has established scholarships at Hayward High School and is active recruiter for UW football team. "Extra-curricular interest: Encourage students to attend college, especially UW Medical School—have three there now." Wife: Edythe M. Daughter: Mary E.

EDYTH C. SWARTHOUT, M.D., West Salem

Born Nov. 8, 1891 at La Crosse, Wis. Attended University of Wisconsin Medical School 1913–17, Johns Hopkins 1918–19. Received M.D. degree 1919, Johns Hopkins. Type of practice: Internist. Interned Johns Hopkins 1919, Bellevue 1920–22. Member of La Crosse County Medical Society, The State Medical Society of Wisconsin, American Medical Association.

H. KENT TENNEY, M.D., Madison

Born May 11, 1892 in Chicago, Ill. Attended Northwestern University Medical School. Received M.D. degree in 1919. Pediatric practice. Member of Dane County Medical Society (president, 1944–45); The State Medical Society of Wisconsin (president, 1953–54); American Academy of Pediatrics (state chairman, 1940–49); Board of Directors of Wisconsin Association of Mental Health (received "Man of the Year" award in 1961); State Mental Health Advisory Committee chairman, 1959; Governor's Commission on Children and Youth, chairman, 1956–60; delegate to White House Conference on Children and Youth, 1950–60; Emeritus Professor of Pediatrics, University of Wisconsin Medical School; Emeritus Professor award, 1965; conducts "March of Medicine" programs on WHA radio throughout Wisconsin. Wife: Jeanette W. Children: Thomas W., Horace Kent III, M.D., Henry Baird.

ERNEST G. WELKE, M.D., Madison

Born Nov. 15, 1888 in Fall Creek, Wis. Attended University of Wisconsin and Marquette University. Received M.D. degree in 1919. General surgery and general practice. Member of State Medical Society of Wisconsin and American Medical Association. Served in World War I and World War II. Wife: Leah S. Children: Joseph, Dorothy, Virginia. □

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Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JULY 9, 1969

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Capata, Ana C., 305 Sunset Place, Neillsville 54456
Filmanowicz, Edward, 7400 Harwood Avenue, Wauwatosa 53213
Fischer-Williams, Mariella, 630 South Central Ave., Marshfield 54449
Grossberg, Josette B., 3005 East Kenwood Blvd., Milwaukee 53211
Guten, Gary N., 949 North 12th St., Milwaukee 53233
Hugerty, Lee H., 969 North 70th St., Milwaukee 53225
Lim, Robert A., 8584 West Appleton Ave., Milwaukee 53225
Maddison, Frank E., 8700 West Wisconsin Ave., Milwaukee 53226
Miech, Michael J., 103 First Ave., West, Menomonie 54751
Qureshi, Mehboob M., 1515 Tenth St., Monroe 53566
Rosenthal, Sheldon A. E., 4427 North 91st St., Milwaukee 53225
Sanguino, Miguel A., 1515 Tenth St., Monroe 53566
Schmitz, Gerald L., 4404 West Oklahoma Ave., Milwaukee 53219
Simonsen, Hubert W., 720 East Wisconsin Ave., Milwaukee 53202
Vogt, Wess Richard, 2136 North 60th St., Milwaukee 53208
Weisberg, Harry F., 948 North 12th St., Milwaukee 53233

CHANGES OF ADDRESS

Adlam, Robert T., Louisville, Ky., to 5242 North Kent Ave., Milwaukee 53217
Alt, Thomas H., APO, New York, to University of Minnesota School of Medicine, Minneapolis, Minn. 55455
Andersen, John T., Milwaukee, to Letterman's General Hospital, Box 59, San Francisco, Calif. 94129
Asinas, I. L., 4359 South Howell Ave., Milwaukee 53207
Bachus, A. C., Box 327, Ripon 54971
Baldwin, R. M., 1920 West Hart Rd., Beloit 53511
Baumann, Robert R., 1515 Tenth St., Monroe 53566
Bogle, W. C., 2400 Whippletree Lane, Brookfield 53005
Brown, E. M., Milwaukee, to 109 Governor St., Richmond, Va. 23200
Brown, Richard C., 733 West Clairemont Ave., Eau Claire 54701
Clifford, Richard M., Milwaukee, to 8531 West Lincoln Ave., West Allis 53227
Connally, Jr., Joseph M., Madison, to 9620 Leaside Dr., Dallas, Tex. 75238
Crittenden, Jay, APO San Francisco, Calif., to FPO, Seattle, Wash. 98765
Davasligil, Hailil, N82 W18046, Coventry Ct., Menomonee Falls 53051
Deardorff, William L., Atlanta, Ga., to 7400 Harwood Ave., Wauwatosa 53213
Deeds, Ernest C., Brookfield, to 2413 Ruger Ave., Janesville 53545
Douglas, Robert F., 1209 South Commercial St., Neenah 54956
Edwards, Richard W., 1313 West Seminary St., Richland Center 53581
Fencil, Wayne J., 1515 Tenth St., Monroe 53566
Finger, William A., Milwaukee, to 323 Crescent Lane, Thiensville 53092
Foregger, Richard, 6780 West Appleton Ave., Milwaukee 53216

Frackelton, W. H., 2266 North Prospect Ave., Suite 608, Milwaukee 53202
Freeman, Lawrence M., Milwaukee, to 8823 Trowlon St., Houston, Tex. 77036
Gandhi, Kishin V., Marshfield, to 6530 Sheridan Rd., Kenosha 53140
Galang, Luis L., Algoma, to Box 282, New London 54961
Gardetto, P. A., 475 Windridge Dr., Racine 53400
Gargas, B. L., 221 Scott St., Wausau 54401
Grade, John O., 1050 Legion Dr., Elm Grove 53122
Hargarten, Lawrence W., Palm Desert, Calif., to 6121 Cedar Dr., Box 106, Burlington 53105
Herzberger, Eugene E., 1515 Tenth St., Monroe 53566
Holzgrafe, Robert E., Milwaukee, to W226 N1509 North Ave., Waukesha 53186
Hulme, A. W., 1011-3rd St., Wisconsin Rapids 54494
Irvin, J. M., 2709-6th St., Monroe 53566
Jekel, J. M., 1706 East Capitol Dr., Milwaukee 53211
Jew, Sik Q., 1616 Tenth St., Monroe 53566
Karabey, Ali B., Box 408, Merrill 54452
Leite, Joaquim, Milwaukee, to 823 Larchmont Rd., Elmira, New York 14905
Lewis, John L., Milwaukee, to 614 Oronoco St., Alexandria, Va. 22314
Lubitz, Joseph M., Milwaukee, to 2828 Interlaken Drive North, Oconomowoc 53066
Lucas, George L., Memphis, Tenn., to 6308 Offshore Dr., Madison 53705
Maddix, Bill L., 1515 Tenth St., Monroe 53566
Marck, Abraham, Toronto, Canada, to 520 Glen Rd., Weston, Mass. 02163
May, James E., Oakland, Calif., to 3426 North Cramer St., Milwaukee 53211
Meyer, Robert J., Menomonie, to Route 2, Box 139A, Spring Valley 54767
Midelfort, Peter A., 733 West Clairemont Ave., Eau Claire 54701
Mirhoseini, Mahmood, Medford, to 1211 Sylvan St., Wausau 54401
Moss, Jr., Hubert V., 30 South Henry St., Madison 53703
Najat, Hushang, 1515 Tenth St., Monroe 53566
Novacek, P. J., Milwaukee, to 2510 Pasadena Blvd., Wauwatosa 53226
Olson, Merlin J., 1515 Tenth St., Monroe 53566
Overgard, A. W., Stanley, to Farmington Apts., 521-3rd St., Farmington, Minn. 55024
Palermo, George B., Milwaukee, to Via Tracia 4, Rome, Italy

Private Die Proprietary Medicine Stamps

This new American Topical Association topical stamp handbook no. 66 (Vol. 4 in the ATA Medical handbook series) documents the history of the proprietary medicine firms using private die stamps approved by the U. S. Internal Revenue Service as well as those using regular revenues with cancellations.

The handbook, by George B. Griffenhagen, author of **Drugs and Pharmacy on Stamps** (Vol. 2 ATA Medical handbook series) presents separate monographs on 132 firms who used these stamps on such remedies as Drake's Plantation Bitters, Dr. William's Pink Pills for Pale People, Mrs. Winslow's Soothing Syrup, and Swaim's Panacea.

This 76-page book, with hundreds of illustrations in 13 full pages and artistic cover by Carl A. Swanson and the author, sells at $4 (40 IRC) from the American Topical Association, 3308 North 50th St., Milwaukee, Wis. 53216. Immediate delivery includes free sample copy of **Topical Time**, ATA's 88-page stamp journal.

Pellicer, Joseph G., Woodland, Wash., to 1407 West Chestnut St., Yakima, Wash. 98902
Phillips, T. A., Owen, to Morgannwg Hospital, Bridgend Glamorgan, Great Britain
Pugh, G. J., Milwaukee, to 110 Gulf View Rd., Punta Gorda, Fla. 33950
Rens, J. L., Phillips, to 4021 Meyer Ave., Madison 53711
Rush, Benjamin M., 1515 Tenth St., Monroe 53566
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Swan, John C., Fond du Lac, to Mount Calvary 53057
Temple, Robert L., Milwaukee, to Community Memorial Hospital, Box 408, Menomonee Falls 53051
Turner, A. J., 811 East Wisconsin Ave., Milwaukee 53202
Tweeten, John B., Minneapolis, Minn., to 3258 South Galena Ct., Denver, Colo. 80222
Valaske, M. J., Great Lakes, Ill., to Naval Medical School, National Naval Medical Center, Bethesda, Md., 20014
Verdone, Anthony J., 3337 North 51st Blvd., Milwaukee 53216
Wade, Chester, Elkhorn, to 4932 Braewild, Rockford, Ill. 61107
Wagelie, R. G., Beloit, to Raymond W. Bliss Army Hospital, Fort Huachuca, Ariz.
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Lavine, Daniel M., Milwaukee County, transferred to Arizona
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DEATHS

Malensek, Martin C., Milwaukee County, Apr. 12, 1969
Hammond, Frederick W., Manitowoc County, May 8, 1969
Smith, Thaddeus D., nonmember, May 8, 1969
Nammacher, T. H., Waukesha County, May 10, 1969
Aageson, Carl W., Dane County, May 15, 1969
Ritchie, Gorton, Milwaukee County, May 24, 1969
Nause, Fred A., Sheboygan County, June 6, 1969
Rettig, Frank E., nonmember, June 7, 1969
Beck, Adam A., Green Lake–Waushara County, June 9, 1969
Sproule, Ralph P., Milwaukee County, June 27, 1969 □

OBITUARIES

Dr. Martin C. Malensek, 64, Wauwatosa physician for 35 years, died Apr. 12, 1969, in Milwaukee.

Born on July 2, 1904, in Eveleth, Minn., Doctor Malensek graduated from the Marquette University School of Medicine in 1932 and did postgraduate work in surgery at the University of Pennsylvania. He interned at St. Elizabeth Hospital in Appleton. Doctor Malensek was on the surgical staff of Deaconess Hospital in Milwaukee and was a fellow of the International College of Surgeons.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Margaret; and two sons, Richard M. and John R., of Milwaukee.

Dr. Gorton Ritchie, 68, prominent Milwaukee pathologist, died May 24, 1969, in Milwaukee.

Doctor Ritchie was born Feb. 18, 1901, in Oak Park, Ill., and graduated from the University of Pennsylvania Medical School in 1927. He interned at Geisinger Memorial Hospital, Danville, Pa.

Doctor Ritchie was on the staff of Columbia Hospital, Milwaukee, where until recently he had been director of laboratories. He was a former director of laboratories at St. Luke's and St. Mary's hospitals, Racine, Milwaukee Children's Hospital, and a former associate professor of medicine, Marquette University School of Medicine. He was also former professor of pathology at the University of Wisconsin Medical School, Madison. He was a member of the American Association of Pathologists and Bacteriologists, American Society of Clinical Pathologists, Milwaukee Academy of Medicine, Milwaukee Internists Club, and the Wisconsin Society of Pathologists which has set up a memorial scholarship fund in his name for the Wisconsin Association of Medical Technologists.

Doctor Ritchie was certified by the American Board of Pathology and was a charter member of the Wisconsin Heart Association.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Georgia; a daughter, Margaret, New York City, and a son, William, Cambridge, Mass.

Dr. Frederick A. Nause, 76, retired Sheboygan physician and surgeon, died June 6, 1969, in Sheboygan.

Doctor Nause, born Sept. 7, 1892, in Sheboygan, was a member of a pioneer Sheboygan family which produced four generations of doctors in the medical service of the community. His father, Dr. Fred W. Nause, died in 1942 as the dean of county medical men after practicing medicine in Sheboygan for 56 years, and his son, Dr. Fred P. Nause, has been practicing medicine in Sheboygan for the past 16 years.

He graduated from Rush Medical College, Chicago, in 1917 and received his commission as medical officer in the United States Naval Medical Corps the same year. He served four years in service during World War I and did postgraduate work at the United States Naval Hospital and Naval Medical School in Washington, D. C. After leaving service he became house physician at Memorial Hospital, Chicago, and in 1921 became engaged in private practice in Sheboygan. He was on the staff of St. Nicholas Hospital, Sheboygan. He served the community for over 40 years until his retirement several years ago.

Doctor Nause received a citation from President Eisenhower for serving 15 years as an uncompensated member of the Selective Service System.

He was civil defense director for many years and remained active in civil defense work until his retirement.

Doctor Nause was instrumental in the establishment of the city's Board of Health and Public Health Department in the 1920s and served as city physician and health officer from 1928–34 and again as part-time health commissioner from 1957–62. He served as vice-president of Sheboygan Memorial Hospital's board, 1933–36, as secretary-treasurer in the late 1940s and early 1950s and as chief of the hospital's staff in 1947–48. In 1932, he was president of the Fifth District Medical Society and in 1937, he was president of the Sheboygan County Medical Society. Doctor Nause served on the Grievance Committee of the State Medical Society of Wisconsin and also was a member of the American Medical Association.

Surviving are his widow, Meta; a son, Dr. Frederick P., and a daughter, Mrs. Thomas J. Detling, Sheboygan.

Dr. Frank E. Rettig, 67, Brookfield, died June 7, 1969, in Brookfield.

Born May 30, 1902, in Austria, Hungary, Doctor Rettig graduated from the Marquette University School of Medicine in 1927. He interned at Marquette University Hospital and did residency work at the University of Vienna and Budapest.

Surviving are his daughter, Mrs. Rosalin Perry, Milwaukee, and a son, Ronald, Brookfield.

Dr. Adam A. Beck, 86, Wautoma general practitioner for over 60 years, died June 9, 1969.

Born on Dec. 14, 1882, Doctor Beck graduated from the Marquette University School of Medicine in 1907 and started his practice in Coloma where he stayed for 13 years. In 1922, he moved to Wautoma and served Waushara County until 1960 when he semi-retired. He still continued to see a few patients until his death.

Active in community affairs, he served as a member of the community school boards, was chairman of the American Red Cross first-aid program and helped establish the first library in Wautoma.

Doctor Beck was a member of the Green Lake–Waushara County Medical Society, member of the State Medical Society's 50-year club, and a member of the American Medical Association.

Surviving are his widow, Agnes; and two physician sons, Dr. Robert W., Roanoke, Va., and Dr. John J., Los Altos, Calif.

Dr. Arthur W. Nuetzman, 66, a former Mosinee physician, died in June in Faribault, Minn., where he had practiced since 1934. □

Clinical Center Study of Hemolytic Anemia

The cooperation of physicians is requested in the referral of patients for studies of idiopathic auto-immune hemolytic anemia being conducted by the National Institute of Allergy and Infectious Diseases at the Clinical Center, National Institutes of Health, Bethesda, Md.

Referrals of patients with Coombs' positive idiopathic auto-immune hemolytic anemia are needed. Also, selected patients with secondary types of auto-immune hemolytic anemia, especially of the cold antibody type, will be accepted.

Studies will be performed to determine the type of antibodies involved and the role of complement in hemolysis. Following this, patients in need of therapy will be treated, and experimental drugs may be used. All patients will be carefully followed during the course of the study. On completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies may write or telephone: Michael M. Frank, MD, or John S. Sergent, MD, Clinical Center, Room 11-N-104, National Institutes of Health, Bethesda, Md. 20014; tel. 301/496–4964. □

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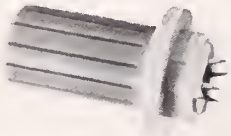

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

BASIC DIAGNOSTIC RADIOLOGY—An Introductory Textbook for Students in the Medical Sciences

By Malcolm D. Jones, MD, C. V. Mosby Company, Saint Louis, Mo., 1969. 266 pages. Price: $11.75

PRACTICAL UROLOGY

By Chester C. Winter, MD, FACS, Professor of Urology, Ohio State University. C. V. Mosby Company, Saint Louis, Mo., 1969. 249 pages. Price: $11.00

THE UNIVERSITY OF WISCONSIN MEDICAL CENTER DIETETIC MANUAL, PART I—For Professional Use

By University of Wisconsin Medical Center—Department of Dietetics, 1968. 148 pages.

THE UNIVERSITY OF WISCONSIN MEDICAL CENTER DIETETIC MANUAL, PART II—For Patient Use

By University of Wisconsin Medical Center—Department of Dietetics, 1968. 400 pages.

MODERN TREATMENT, Vol. 6, No. 2

Treatment of Obstructive Pulmonary Insufficiency, guest editor, Edwin Rayner Levine, MD; and Treatment of Lymphedema, guest editor, Alexander Schirger, MD. Hoeber Medical Division, Harper & Row, Publishers, 49 East 33 St., New York, N.Y. 10016. Published bimonthly. 1,500 pages annually. Subscription: $16 per year

PROFILES OF BURN MANAGEMENT

By Nelson H. Stone, MD, PhD and John A. Boswick, Jr., MD. Industrial Medicine Publishing Co., Inc., Medical Book Division, Miami, Fla. 33156, 1969. 51 pages. Price: $5.00

SYMPOSIUM ON THE SPINE

By American Academy of Orthopaedic Surgeons. C. V. Mosby Company, Saint Louis, Mo., 1969. 289 pages. Price: $19.50

THE NEW HEART

By Brian R. Boylan. Chilton Book Company, Philadelphia, Pa., 1969. 211 pages. Price: $4.95

ORGANIZATION AND ADMINISTRATION OF HEALTH CARE

By Richard L. Durbin and W. Herbert Springall. C. V. Mosby Company, Saint Louis, Mo., 1969. 249 pages. Price: $9.85

ESSENTIALS OF GASTROENTEROLOGY

By Ned Smith, Jr., MD, Associate Professor of Medicine, University of Missouri, Columbia, Mo. C. V. Mosby Company, Saint Louis, Mo., 1969. 326 pages. Price: $14.75

GENETICS AND COUNSELING IN MEDICAL PRACTICE

By Leonard E. Reisman, MD and Adam P. Matheny, Jr. PhD. C. V. Mosby Company, Saint Louis, Mo., 1969. 215 pages. Price: $12.75

ADRENERGIC NEUROTRANSMISSION (Study Group #33 Cibo Foundotionl

Edited by G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown and Co., 34 Beacon St., Boston, Mass. 02106. 1969. 123 pages. Price: $4.50

THE ROLE OF LEARNING IN PSYCHOTHERAPY (Ciba Foundotion Symposium)

Edited by Ruth Porter. Little, Brown and Co., 34 Beacon St., Boston, Mass. 02106. 340 pages. Price: $12.00

PHYSICAL DIAGNOSIS—The History ond Examination of the Potient

By John A. Prior, MD and Jack S. Silberstein, MD. The C. V. Mosby Company, St. Louis, Mo. 1969. 436 pages. Price: $10.50

THERAPEUTIC RADIOLOGY

By William T. Moss, MD and William N. Brand, MD. The C. V. Mosby Company, St. Louis, Mo. 1969. 564 pages. Price: $22.50

INTERNATIONAL COMPARISONS OF MEDICAL CARE UTILIZATION

U. S. Department of Health, Education, and Welfare. Series 2, No. 33. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 75 pages. Price: 70¢

COMPARABILITY OF MARITAL STATUS, RACE, NATIVITY, AND COUNTRY OF ORIGIN ON THE DEATH CERTIFICATE AND MATCHING CENSUS RECORD

U.S. Department of Health, Education, and Welfare. Series 2, No. 34. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 47 pages. Price: 50¢

PROBLEMS IN CHILD BEHAVIOR AND DEVELOPMENT

By Milton J. E. Senn, MD and Albert J. Solnit, MD. Lea & Febiger, 600 Washington Square, Philadelphia, Pa. 19106. 1968. 268 pages. Price: $8.50

INTERNAL MEDICINE IN WORLD WAR II—INFECTIOUS DISEASES AND GENERAL MEDICINE, VOL. III

Office of the Surgeon General, Department of the Army, Washington, D. C. 1968. Superintendent of Documents, Government Printing Office, Washington, D. C. 20402. 778 pages. Price: $8.25

BOOK REVIEWS

NURSING EDUCATION IN COMMUNITY JUNIOR COLLEGES

A Four-State, Five-Year Experience in the Development of Associate Degree Programs, by Bernice E. Anderson, Ed.D., professor emeritus of nursing education, Teachers College, Columbia University. J. B. Lippincott Co. Philadelphia. 1966. 319 pages.

This book describes a Four-State Project in the development of nursing education in community junior colleges, the most rapidly expanding programs for the preparation of registered nurses in the United States. The project extended from 1959 to 1964 and was supported by the W. K. Kellogg Foundation. The purposes were to assist in planning and activating new junior college programs in nursing and to prepare nursing faculty to staff them.

The report of this project is divided into three parts, namely: historical aspects; case studies of the program development in the four participating states—California, Florida, New York, and Texas; an appraisal of the project accomplishments.

The project aims were accomplished successfully in California, Florida, and New York. The outcomes were less successful in Texas. Factors contributing to success and failure of these programs are discussed.

From 1952 to 1957, another five-year Cooperative Project demonstrated that individuals could be educated successfully to qualify for practice as registered nurses in two-year associate degree programs in community junior colleges.

Detailed descriptive material about organization and administration, curriculum development, and evaluation in each state project is included. This material makes it clear that variation exists among junior college programs and this seems desirable. Support of State Boards of Nursing in California, Texas, and New York was an important factor in making it possible to test out new approaches in these programs.

The final chapter reflects the author's viewpoints about the outcomes of this Project and the future expansion of nursing programs in community junior colleges. She expresses a positive viewpoint about the need for and development of these programs. Problems and issues that need further consideration are identified.

The experiences within the Four-State Project described in this book should be valuable to those interested in learning about and/or in planning for nursing programs in junior community colleges. Also, directors of nursing, physicians, and hospital administrators who will be employing the graduates of these programs are encouraged to read the report of this Project. It is stated that the final test of the outcomes of this new education program for nursing will be "the ability of graduates to demonstrate quality performance of bedside nursing care."—LOUISE C. SMITH, Ed. D., R.N.

THE CARE OF THE GERIATRIC PATIENT (3rd Editionl

Edited by E. V. Cowdry, Ph.D., Consultant to the Jewish Hospital of Saint Louis. Published by C. V. Mosby Company, 1968. 430 pages. Price: $15.75.

Cowdry's third edition of "The Care of the Geriatric Patient" is a welcome addition to the literature of an important field of medicine. The 10 percent of the population over 65 years old in the United States alone arrests attention. Under his editorial guidance, Doctor Cowdry has enlisted an imposing group of collaborators whose contributions are at once basically instructive and practical. In the preface, the editor indicates a design for especial attention to the specialties. The spiritual and sociological aspects of aging are given due attention.

As is inevitable when a number of individuals are dealing with their special interests, unequal weights are given to related and unrelated subjects. The new chapter on "Aspects of Exercise" is splendid. However, its author delves more deeply into pathophysiology than in any other chapter. (And the reviewer liked it!) The psychology of the aging cannot be overemphasized. This subject is especially well treated. The authors on "Nutritional Aspects" who recommended certain viscera "for *economic* as

well as nutritional reasons" (page 170), have not priced calves liver recently.

When we move to specific medical, surgical and psychiatric disturbances, we realize that only guideposts for further study can be afforded in a text with such broad terms of reference. The section on rehabilitation is quite provocative. Its author, doubtless, wished to stir the profession from its apparent apathy toward this vital element of medical practice by assigning a fictitious patient role to himself. He concludes on a much more optimistic and constructive note.

Twenty-three percent of the pages of this distinctive volume are devoted to the home and institutional care of the aging individual (including rehabilitation). This assignment of space is entirely appropriate. In our present and prospective socioeconomic setting, these considerations take a prominent place. However, in the economy of space one might question the inclusion of the forms (5) for the Extended Care Unit.

Carried through in several expositions is the obvious contention that aging is a process natural to all living matter. Elsewhere it has been indicated that "Through science and civilization man has modified many of nature's devices to maintain biological balance. It now behooves man to adjust his manner of life to survive healthfully and happily in the world he has made." The dignity of death is repeatedly emphasized. "Why ward off death, if in the attempt we kill living?" (Longcope)—WILLIAM S. MIDDLETON, M.D.

THE FEMININE MIND AND BODY

By J. Dudley Chapman, D. O., President of the American College of Osteopathic Obstetricians and Gynecologists and a Diplomate of the American Osteopathic Board of Obstetrics and Gynecology. Philosophical Library, Inc., New York, N. Y. 1967. 325 pages, Price: $6.95.

The Feminine Mind and Body, written by Dr. Chapman is aimed at being an "adjunctive text for the medical student and the physician treating women." It is divided into three parts. The first being a rough, restatement of Freudian developmental psychology through the adolescent period. The second, a survey of problems besetting the "mature" woman with a liberal sprinkling of case histories. Finally, a look at the woman as she approaches menopause, a small section on cybernetics (I am not sure why) and some "existential goals and tenets for emotional freedom."

Any work which attempts to bridge the wide psychosomatic gap, especially in the area of sexuality, has some value but this book is not effective at what it attempts to do. Perhaps it tries to cover too much, for the reader is often left with the impression that one early misconception will damage one for life or that every symptom always is the outcome of a certain conflict.

Being a curious mixture of a number of impressive references (many psychoanalytic) which are intrinsically difficult to translate to pragmatics, and folksy, exhortive cliches, its totality falls somewhere between a textbook and a "do-it-yourself" manual for mental health. It is worth reading for the feminine psychological theory in it but the artificiality dampens one's enthusiasm. It could use more of Dr. Chapman's warmth, experience, and self which the reader only occasionally glimpses.—JOHN R. MARSHALL, MD

THE BALKAN NEPHROPATHY

Ciba Foundation Study Group No. 30. Little, Brown & Co., Boston, 1968. 125 pages. Price: $3.50

This book is of special interest to epidemiologists and physicians concerned with renal disease. It is a collection of papers describing studies on the causation of Balkan or endemic nephropathy, a form of chronic progressive renal disease unknown in most parts of the world but strikingly prevalent in very localized areas of the Balkan states, and hence its name.

Clinically, the disease is characterized by a strong familial tendency, an insidius onset usually after age 25 or 30, the progressive weakness, lassitude and pallor characteristic of other forms of chronic renal failure, but usually without hypertension or fluid retention. Proteinuria (often of the "tubular" variety), azotemia with disproportionately severe anemia, and finally a fatal outcome, are typical of symptomatic cases. Pathologically, the kidneys are very small and show much tubular degeneration and interstitial fibrosis.

Thus far, the precise cause remains unknown. This book describes detailed studies of affected families, the geographic distribution of cases, microbiological studies of endemic villages, trace metal investigations of patients, water supplies, food and soil; and other epidemiologic aspects of this interesting variant of renal disease. In addition, studies of urinary proteins and tubular function are described. Despite a strong familial pattern, the investigations to date suggest that the probable cause is a still unclarified toxic factor from the environment which slowly injures the renal tubules and causes interstitial fibrosis and eventual uremia.

Continuation of similar lines of research will probably clarify the pathogenesis of this disorder. A similar multi-faceted attack on cause and prevention of other perplexing renal diseases might fruitfully be made by interested investigators. If only these disorders were as well localized geographically as the Balkan nephropathy!—MARGARET NEWTON, MD

ANTILYMPHOCYTIC SERUM

Ciba Foundation Study Group No. 29, Little, Brown and Company, Boston, 1967. 165 pages.

The CIBA Foundation symposium on antilymphocytic serum is a useful monograph to the researcher in the field of transplantation. Six papers from hospitals in the United States, England, Scotland, the Netherlands, and Japan are presented from the symposium held on January 20, 1967. An additional value of these monographs is the very good discussion held after each paper and in conclusion. The unfortunate thing about this type of publication is that it is almost two years old at the present time, in a very fast-moving field, so that one can only consider it a source of references but would have to consider that much of this type of research has gone on in the past two years.

The limitations of this type of monograph are its late publication; it does not substitute for a textbook and is not as satisfactory as a review of the current literature.—DONALD KORST, M.D. □

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COUNTY MEDICAL SOCIETIES

Presidents and secretaries of the 54 component county medical societies are listed periodically.

MEDICAL MEETINGS
POSTGRADUATE COURSES

1969 WISCONSIN

Oct. 1: 4th annual Symposium of Adolf Gundersen Medical Foundation and Wisconsin Heart Association entitled "Acute Myocardial Infarction," La Crosse.

Oct. 3: Fall Pediatric Day, Wisconsin Academy of Pediatrics and University of Wisconsin Department of Pediatrics, Wisconsin Center, Madison.

Oct. 3–4: Annual meeting, Easter Seal Society of Wisconsin, Beaumont Motor Inn, Green Bay.

Oct. 3–4: Sixth Annual Symposium—Women and the Future, Milwaukee Psychiatric Hospital, at Pfister Hotel, Milwaukee.

Oct. 6–10: Wisconsin Work Week of Health, State Medical Society, to be held each day in a different city: Eau Claire, Wausau, Green Bay, Milwaukee, and Madison.

Oct. 8–9: Annual meeting, Wisconsin Academy of General Practice, Holiday Inn No. 2, Madison.

Oct. 8–11: Annual Convention, Wisconsin Nurses Association, Sheraton–Schroeder Hotel, Milwaukee.

Oct. 8, Nov. 12, Dec. 10: Troika seminar for physicians and dentists on Geriatric Dentistry, St. Francis Hospital, Milwaukee.

Oct. 20–22: An Aggressive Approach to Coronary Heart Disease: The Present State of the Art, American College of Cardiology and Marquette School of Medicine, Pfister Hotel, Milwaukee.

Oct. 25: One-day Pediatric Symposium, Marshfield Clinic, Marshfield.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton–Schroeder Hotel, Milwaukee.

Nov. 22: Fall meeting, Wisconsin Society of Pathologists, St. Mary's Hospital, Madison.

1969 NEIGHBORING STATES

Oct. 4–10: Annual Otolaryngologic Assembly of 1969, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Oct. 9–11: Eye-Bank Association of America, Chicago, Ill. (Exec. Dir.: William B. Clark, MD, 1111 Tulane Ave., New Orleans, La. 70112).

Oct. 10–11: American Society of Ophthalmologic and Otorhinolaryngologic Allergy, Chicago, Ill.

Oct. 11–12: American Association of Ophthalmology, Chicago, Ill.

Oct. 12–17: American Academy of Ophthalmology and Otolaryngology, Chicago, Ill.

Oct. 15: Fifth annual professional symposium on Recent Advances in Renal Disease, Kidney Foundation of Illinois, LaSalle Hotel, Chicago.

Oct. 16–17: American Association for Automotive Medicine, Mayo Auditorium, Minneapolis, Minn.

Oct. 17–18: General Practitioners In-House Conference, University of Iowa, Iowa City.

Oct. 18–23: Annual meeting, American Academy of Pediatrics, Palmer House Hotel, Chicago.

Oct. 23–25: Conference on Surgery, University of Iowa, Iowa City.

Oct. 29–30: American Association for the Study of Liver Disease, Chicago, Ill.

Oct. 29–Nov. 2: American College of Chest Physicians, Chicago, Ill.

Nov.: American Society of Therapeutic Radiologists, Chicago, Ill.

Nov. 2–5: International Symposium on Atherosclerosis, Chicago, Ill.

Nov. 3–5: Clinical Reviews (to be repeated on Nov. 10–12), Mayo Clinic and Mayo Foundation, Rochester, Minn.

Nov. 3–7: Nuclear Medicine—Diagnosis and Treatment of Disease with Radionuclides Given Internally, American College of Physicians, University of Michigan Medical Center, Ann Arbor.

Nov. 3–14: Postgraduate course in Laryngology and Bronchoesophagology, Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago.

Nov. 8–9: North Central Medical Conference, St. Paul Hilton, St. Paul Minn.

Nov. 8–9: Conference on Radiology, University of Iowa Health Center, Iowa City.

Nov. 10–12: Clinical Reviews (repeat of Nov. 3–5), Mayo Clinic and Mayo Foundation, Rochester, Minn.

Nov. 11–15: American College of Preventive Medicine, Detroit, Mich.

Nov. 21–22: Workshop on the Delivery of Medical Care in the 1970s, Institute of Medicine of Chicago, Ambassador Hotel, Chicago.

Nov. 28–29: Head and Neck Radiology Conference, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Nov. 30–Dec. 5: Radiological Society of North America, Chicago, Ill.

Dec. 4–5: Conference on Obstetrics and Gynecology, University of Iowa Health Center, Iowa City.

Dec. 5–6: Cardiac and Respiratory Disease Conference, University of Iowa Health Center, Iowa City.

1969 OTHERS

Oct. 6: International Symposium on Early Disease Detection, Elkhart, Ind.

Oct. 6–10: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 6–10: Family Practice Symposium, Medical College of Georgia, Gwinnett at Fifteenth Street, Augusta, Ga. (tel. 724–7111, ext. 349 or 683).

Oct. 7–11: Western Conference of Prepaid Plans, Sun Valley, Idaho.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 22–24: 16th Western Cardiac Conference, University of Colorado Medical Center, Denver, Colo.

Oct. 27: Oral Cancer Seminar, University of Colorado School of Medicine, Denver.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 12–15: Postgraduate conference, Mound Park Hospital Foundation and University of Florida, Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Nov. 17–21: Course in Neuroradiology with Clinical and Pathological Correlation, New York University Post-Graduate Medical School, New York.

Nov. 19–21: Emergency Service Procedures, University of Colorado School of Medicine, Denver.

Nov. 20: Annual Membership Meeting, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Dec. 8–11: Sixth Annual New Orleans Course on Pulmonary Function in Health and Disease, American Thoracic Society with others, Louisiana State University School of Medicine Auditorium, New Orleans.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium). Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psychosomatic Seminars), to South Pacific.

1969 AMA

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

May 11–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 NEIGHBORING STATES

Feb. 16–18: Sectional Meeting, American College of Surgeons, St. Paul Hilton, St. Paul, Minn.

Mar. 16–20: Clinical Problems in Internal Medicine, American College of Physicians, Cleveland, Ohio.

Mar. 23–26: Neurology and the Internist, American College of Physicians, Rochester, Minn.

Mar. 30–Apr. 3: Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, American College of Physicians, Ann Arbor, Mich.

June 8–12: Internal Medicine, 1970—Old Principles, New Practice, American College of Physicians, Iowa City, Iowa.

June 15–17: Blood Transfusion Therapy and Related Immunology, American College of Physicians, East Lansing, Mich.

Oct. 5–9: 53rd Annual Meeting, American Dietetic Association, Detroit, Mich.

1970 OTHERS

Jan. 9: Sectional Meeting, American College of Surgeons, Americana Hotel, San Juan, Puerto Rico.

Jan. 16–17: Sectional Meeting, American College of Surgeons, Mancuto–Sheraton Hotel, Caracas, Venezuela.

Jan. 18–24: Sixteenth Annual General Practice Review, University of Colorado School of Medicine, Denver.

Jan. 21–23: Sectional Meeting, American College of Surgeons, El Panama Hotel, Panama City, Panama.

Feb. 2–4: Sectional Meeting, American College of Surgeons, Portland Hotel, Portland, Ore.

Feb. 2–6: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Feb. 14–21: Fourth Annual Alumni/Faculty Retreat, Wisconsin Medical Alumni Association, Puerto Vallarte, Mexico.

Mar. 16–18: Sectional Meeting, American College of Surgeons, Sheraton Park Hotel, Washington, D.C. (Combined annual meeting for surgeons and nurses).

Mar. 9–27: Course for physicians in Occupational and Environmental Medicine, New York University Post-Graduate Medical School, New York.

Apr. 6–10: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Apr. 26–30: First International Congress on Group Medicine, Winnipeg, Manitoba, Canada.

May 7–9: Annual Meeting, American College of Sports Medicine, Albuquerque, N.M. (Exec. Secy.: Mr. Donald E. Herrmann, 1440 Monroe St., Madison, Wis. 53706).

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

Dec. 6–11: Second International Clean Air Congress, Washington, D. C.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1971 OTHERS

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the **Journal of the American Medical Association.**

Pediatric Symposium—Marshfield

A one-day Pediatric Symposium will be held Saturday, Oct. 25, starting at 9 a.m. in the library at the Marshfield Clinic, Marshfield. It is sponsored by the Clinic's Pediatrics Department and the Clinic Foundation. Dr. George Griese, program chairman, has announced that the guest speaker will be Dr. David Smith, associate professor of pediatrics at Temple University Medical School, Philadelphia. All interested physicians are welcome.

Medical Oncology Today—Minnesota

The American College of Physicians will present a course on *Medical Oncology Today* at the University of Minnesota School of Medicine, Minneapolis, Oct. 8–11.

Fees: $60, members; $100, nonmembers. Registration and information to: Edward C. Rosenow, Jr., MD, FACP, Executive Director, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Pediatric Dermatology—Milwaukee

A clinical meeting on *Pediatric Dermatology* will be held Nov. 8 at the Milwaukee Children's Hospital. This is jointly sponsored by the Wisconsin Dermatological Society and Milwaukee Children's Hospital.

A social hour and dinner will follow the meeting at the Milwaukee Athletic Club. Guest discussant will be Dr. Carroll F. Burgoon, Jr. of Temple University Health Sciences Center, School of Medicine, Philadelphia, Pa.

Inquiries are welcomed by R. J. Scrimenti, MD, Secretary, Wisconsin Dermatological Society, or Donald M. Ruch, MD, Dermatology Department, Children's Hospital. Address: 740 Marine Plaza, Milwaukee 53202. Tel.: 414/276–2306.

Troika Seminar on Geriatric Dentistry

A troika seminar for physicians and dentists on the subject of *Geriatric Dentistry* will be held on three Wednesdays in the fall at St. Francis Hospital, Milwaukee.

Conducting the seminar will be Arthur Elfenbaum, BA, DDS, Senior Attending Member of Medical Staff, Michael Reese Hospital and Medical Center, Chicago; President and Editor of American Society for Geriatric Dentistry; and Professor Emeritus, University of Illinois and Northwestern University.

Dr. Elfenbaum's purpose will be the inauguration of coordinated health treatment and preventive plans for physicians and dentists in order to provide total health care for geriatric patients.

The Seminar is being presented jointly by St. Francis Hospital and Marquette University School of Dentistry. It has been made possible by a grant from the St. Francis Hospital Foundation and donations from several manufacturing companies.

Dates of the continuing seminar are *Wednesday, October 8, Wednesday, November 12* and *Wednesday, December 10.* Time will be 8:30 a.m. to 4:30 p.m.; luncheon will be served through the courtesy of St. Francis Hospital. Participants will meet in the seventh floor auditorium of the hospital.

The seminar has been arranged by Louis B. Uszler, MD, Chief of Staff, St. Francis Hospital; Joseph L. Heffner, DDS, Chief of Dental Staff, St. Francis Hospital; and Fred R. Salerno, DDS, Chairman, Department of Preventive Dentistry and Community Health, Marquette University School of Dentistry.

There will be no registration fee, but reservations (limited to 110) are necessary and may be made with: Joseph L. Heffner, DDS, Chief of Dental Staff, St. Francis Hospital, 3237 South 16th Street, Milwaukee, Wis. 53217.

General Practitioners Conference—Iowa

General practitioners of medicine will have an opportunity to visit and participate in the work of the clinical departments at The University of Iowa Hospitals on Friday and Saturday, Oct. 17–18.

Physicians who attend the in-house conference will join the U of I clinical staff on Friday for rounds, conferences, out-patient clinics, work in the operating rooms, diagnostic studies, and other activities. On Saturday, physicians can attend any of the regular teaching conferences.

Those who plan to attend can select in advance the departments in which they wish to work and the conferences they wish to attend on Saturday. Choices may be for different departments each day, but physicians should plan to register early since assignments must be made on a first-come, first-served basis.

Conference registration forms can be obtained by writing: Director, Office of Medical Education, The University of Iowa, 100 Westlawn, Iowa City, Iowa 52240.

Postgraduate Medical Education—Colorado

The following postgraduate medical education courses have been scheduled by the University of Colorado School of Medicine:

Hospital Medical Staff Conference—Sept. 29–Oct. 3, Estes Park, Colo.

Oral Cancer Seminar—Oct. 27

Emergency Service Procedures—Nov. 19–21

Sixteenth Annual General Practice Review—Jan. 18–24, 1970

High Risk Infant Care (limited)—Oct. 6–10, 1969; Feb. 2–6, 1970; and Apr. 6–10, 1970.

Contact: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

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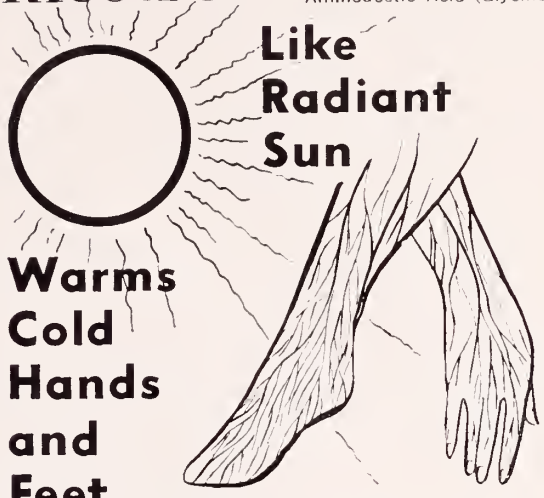

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1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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American College of Surgeons

The American College of Surgeons has scheduled three 1970 Sectional meetings in the United States and one each in Puerto Rico, Venezuela and Panama. These short, concentrated scientific sessions are open to all doctors of medicine.

Cities and dates in the United States are:

PORTLAND, OREGON, Feb. 2–4. Portland Hotel.

ST. PAUL, MINNESOTA, Feb. 16–18. St. Paul Hilton.

WASHINGTON, D.C., Mar. 16–18. Sheraton Park Hotel. This is the annual combined meeting for surgeons and nurses.

Meeting cities and dates for the programs in Puerto Rico, Venezuela and Panama are:

SAN JUAN, Jan. 9, Americana Hotel.

CARACAS, Jan. 16–17, Mancuto–Sheraton Hotel.

PANAMA CITY, Jan. 21–23, El Panama Hotel.

For those interested, these three meetings may be combined with a scientific winter cruise with shipboard sessions, leaving from Port Everglades, Florida, on Jan. 7 and returning to Fort Lauderdale, Florida, on Jan. 27. Address inquiries regarding this cruise to Dr. Robert J. Kamish, assistant director, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611.

Sectional meetings are held in strategically located cities throughout North America and other countries and are planned to inform the medical profession at large about developments in surgery. Leading surgeons hold panel discussions, "how-I-do-it" clinics, and symposia on newer ways of handling surgical problems. Scientific papers and selected films are also presented. Each meeting features sessions in general surgery and three or more surgical specialties.

Portland, Oregon, Feb. 2–4, Portland Hilton.

There will be programs for specialists in gynecology and obstetrics, thoracic and cardiovascular surgery and proctology in addition to general surgery sessions.

Among subjects to be discussed will be metabolic changes in the surgical patient, radioactive isotopes in diagnosis and treatment, selective vagotomy, emergency care of the traumatized patient, lessons of the Viet Nam War, the lump on the neck, soft tissue sarcomas, problems in gastro-duodenal surgery, emergency surgery of the newborn, diagnosis and treatment of pulmonary insufficiency, coronary arteriography and office treatment of hemorrhoids.

St. Paul, Minn., Feb. 16–18, St. Paul Hilton.

Separate sessions will be held in thoracic surgery, urology, and otorhinolaryngology, as well as in general surgery.

Topics of interest include breast cancer, penetrating injuries of the neck—experiences in Vietnam and Denver, intestinal angina, methods and results of vena cava interruption, compound fractures treated with massive doses of antibiotics, transportation of the injured, monitor techniques, carotid endarterectomy, rhinoplasty and septoplasty, complications of tracheostomy, thoracic emergencies in the newborn, arterial surgery for renal disease, dialysis and transplantation.

Washington, D.C., March 16–18, Sheraton Park Hotel.

This is the 17th combined doctor-nurse meeting sponsored by the College.

As guests of the College, nurses pay no registration fee.

In addition to general surgery sessions, there will be programs in seven specialties: gynecology-obstetrics, neurosurgery, ophthalmology, otolaryngology, plastic surgery and urology.

General surgery topics include complications of gastrointestinal surgery, surgery of the esophagus, advances in chemotherapy and renal transplantation. Specialty subjects include management of neurogenic bladder, the child with middle ear effusion, tumors of the larynx, glaucoma—when and how to operate, infertility in the female, amniotic fluid studies, microinvasive carcinoma, management of combat facial wounds, treatment of the arthritic hand, modern concepts in the treatment of osteomyelitis and long term results of cervical disc surgery.

Nurses' sessions will include discussions on postoperative complications and management of thoracic surgery patients, current status of the operating room technician and medical assistant, dynamic trends in the treatment of contamination, microbiology, burns and electrocutions from monitoring and other electrical equipment, and chromosomes and malignancies.

American Heart Association—Texas

The 1969 Scientific Sessions of the American Heart Association will be held Nov. 13–16 in Dallas, Tex.

The four-day period features eight sessions on clinical cardiology of special interest to the practicing physician, simultaneous sessions on various aspects of cardiovascular research and medicine, lectures, panels, symposia, and an all-day showing of recently-produced cardiovascular films.

Highlights of the meeting include presentation of the Research Achievement Award; the International Lecture by Dr. J. Fraser Mustard; the Conner Memorial Lecture, and the Brown Memorial Lecture.

Saturday evening's program features a number of conferences for small group discussion of cardiovascular problems.

Registration forms are available from the AHA, 44 East 23rd Street, New York, N.Y. 10010; tel. 212/477–9170, and from the Wisconsin Heart Association, Steinmeyer Bldg., 205 West Highland Ave., Milwaukee, Wis. 53203; tel. 414/272–4246.

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PRESIDENT'S PAGE

ROBERT E. CALLAN, M. D.

YOUTH AND HEALTH IN PROPER PERSPECTIVE

THE SEVENTH ANNUAL Work Week of Health, sponsored by the State Medical Society of Wisconsin, will go on the road October 6–10, with one day stands in Green Bay, Wausau, Eau Claire, Milwaukee, and Madison. Last year's "Youth on a Four-Day Trip" was a spectacular success with a total attendance in Madison of 3,415 persons.

Theme of the meetings this year will continue to be on youth and health with emphasis on the topics of major importance as indicated by the interest in the 1968 program, including drugs, sex and the teenager, alcohol, smoking, and emotional problems. We shall "tell it as it is"—fact not fiction—from the medical point of view.

A recent study found that students with drug problems are most likely to accept advice from practicing physicians and people in the field of academic medicine. It was found also that in order to be effective, the physician must be knowledgeable and give his advice in an honest and scientific manner so as to dispel the great misunderstanding and misinformation prevalent today. The recently noticed reduction in the use of LSD has been credited in part to the widely disseminated information of the chromosomal effects of the drug.

Many of the problems of youth today are within the province of medicine. Physicians and county medical societies must assume a more active role in health education in these fields of great significance to our young people.

Currently, nothing seems more controversial than the question of sex and family life education in the schools. Our State Society's House of Delegates this last May put us on record as approving and encouraging proper instruction in family life and sex education in the schools. Because "proper instruction" needs amplification to provide helpful guidelines to communities concerned with this problem, it seems timely to reprint here the recently adopted resolution on the subject by the American Medical Association in July:

> WHEREAS, The traditional sources of sex information and guidance for young people are often inadequate; and
>
> WHEREAS, The local public and parochial schools—as social institutions accessible to all young people, reflecting broad community support and with sufficient intellectual and material resources—can aid substantially in the development of sound individual codes of sexual behavior; therefore be it
>
> *Resolved,* That the American Medical Association recognizes that the primary responsibility for family life education is in the home, but that the AMA support in principle the inauguration by State Boards of Education or school districts, whichever is applicable, of a voluntary family life and sex education program at appropriate grade levels:
>
> (1) as part of an overall health education program;
> (2) presented in a manner commensurate with the maturation level of the students;
> (3) following a professionally developed curriculum foreviewed by representative parents;
> (4) including ample and continuing involvement of parents and other concerned members of the community;
> (5) developed around a system of values defined and delineated by representatives comprising physicians, educators, the clergy, and other appropriate groups; and
> (6) utilizing classroom teachers and other professionals who have an aptitude for working with young people and who have received special training; and be it further
>
> *Resolved,* That local organizations be urged to utilize physicians as consultants, advisors, and resource persons in the development and guidance of such curriculum and that state and county medical associations be urged to take an active role in this participation.

The reference committee which recommended the above resolution also defined sex education as "instruction to strengthen family life, to increase self-understanding and self-respect, to develop capacities for good human relationships, to build sexual and social responsibility, and to enhance competency for responsible parenthood. It is *not* concerned with sexual techniques or sexual deviations."

Dr. E. James Lieberman, chief of the Center for Studies of Child and Family Mental Health at the National Institute of Mental Health, probably puts the whole topic in proper focus with this statement:

"The most important sex education is that of healthy masculine and feminine identification. This comes ideally from parents who show each other affection, who relate well to their children . . . but who keep the bedroom door closed."

There still is no substitute for common sense.

Robert E. Callan M.D.

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S. E. Sivertson, M.D._____Madison
E. C. Albright, M.D._____Madison
R. H. Wasserburger, M.D._____Madison

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Double Standard

CASUALLY, WITHOUT PUBLICITY or fanfare, the Food and Drug Administration decertified 10 generic oxytetracyclines, the products of 10 different manufacturers. The action was taken after the FDA verified that the generic products were not equivalent to Pfizer Laboratories' Terramycin, the original certified oxytetracycline, for which they were supposed to have been identical replacements.

Specifically, Pfizer found that the generic drugs competing with Terramycin failed to produce blood levels equivalent to the original branded drug. Only after studies by the FDA confirmed Pfizer findings did decertification take place. To this date, the identity of the manufacturers involved has not been made public, and those doctors who prescribed a generic oxytetracycline will probably never know if their patients received a drug having the efficacy they intended.

All of this matter-of-factness and indifference contrasts strikingly with the hullabaloo that accompanied the recent decertification—although for a different reason—of a brand-name drug, Panalba. The press reports would have led the reader to believe that its manufacturer was a conniving parasite growing rich on the helplessness of the public with the cooperation of the greedy medical profession. The Panalba case provided more ammunition for those health-care economists who seem to believe that medical treatment is too important to be left to physicians, and who are convinced that there is no difference between a brand-name drug and its less expensive generic "equivalent." For whatever reason a brand-name drug is decertified the attendant notoriety seems to offer proof to the medical surrogates that they are justified in attempting to force physicians to prescribe drugs for economic reasons rather than for medical reasons.

Since the decertification of the 10 generic drugs punctures the arguments of the legislative enemies of the pharmaceutical industry, the action was taken quietly. When Dr. Herbert Ley, FDA Commissioner, was asked, in an interview reported in MEDICAL TRIBUNE of July 17, 1969, why the decertification action was taken without the usual publicity the FDA generates when it decertifies a brand-name drug, he replied that the move with respect to the oxytetracyclines came at a time when there was internal dissension about how to proceed with generic testing so as to establish a scientifically acceptable policy.

It is difficult to avoid the conclusion that the FDA was concerned less with its own consensus than it was with the feeble position of a number of legislators. Dr. John Jennings, director of the FDA Bureau of Medicine, tried to save the day by pointing out that the decertification occurred on the basis of comparability, not efficacy. "How," he is quoted as saying, "do we know that lower oxytetracyline blood levels are not effective?" The answer, of course, is to compel the manufacturers of the decertified oxytetracyclines to produce the same demonstration of efficacy as was required of Pfizer Laboratories before Terramycin was certified.

However it happened, it is encouraging that the FDA is addressing itself to the problem of investigating actual equivalency of generic drugs vis-a-vis original brand-name preparations. The agency has requested more money from the House Appropriations Subcommittee on Labor for this purpose. Until now, most cases of decertification have been instigated by brand-name manufacturers who produced evidence of lack of comparability in generic competitive products. No one knows how many generic drugs of all types actually lack comparability. Hopefully, the FDA will demand from manufacturers of generic pharmaceuticals documented evidence of equivalency with a brand-name reference drug. When that happens, and the makers of generic drugs begin to assume the same responsibility for their products as does the brand-name manufacturer, physicians may be less reluctant to prescribe generically.

In the meantime welfare departments on economy kicks and uninformed legislators should proceed cautiously in their advocacy of generic prescribing. The choice of a therapeutic drug should be left to the prescribing physician, with no element of that choice automatically left to a pharmacist or purchasing agent. It is the height of folly to expose welfare recipients or anyone else to the hazard of having to receive a drug in which their physicians may not have confidence, and which may not do the job for which it was prescribed.

Dr. Alfred Gilman, chairman of the drug study committee of the National Academy of Sciences, National Research Council, summed up the matter by pointing out that lack of equivalency may be a rare occurrence in vitro, but "when it's a matter of crossing the mucosal barrier, that is another issue." He predicted that the FDA would be surprised at the lack of equivalency as they start reexamining important old drugs.

Until the FDA can establish the proper protocols for testing equivalencies and gets the testing mechanisms into motion, physicians would be well advised to stick with the pharmaceuticals in which they have confidence and which have, indeed, received new-drug certification. And nonprofessional experts in the field of health care would be well advised to stop trying to fetter the physician in his choice of therapeutic agents.—D.N.G. □

NEW OFFICE LABORATORY PROFICIENCY EVALUATION PROGRAM

An opportunity for physicians to evaluate their own laboratories' proficiency and quality control now is being offered in a new Office Laboratory Proficiency Evaluation Program designed by the College of American Pathologists for general practitioners, internists, pediatricians, and others.

Russell J. Eilers, MD, chairman of the CAP's Standards Committee, said the Proficiency Evaluation Program is directed to the physician who does limited laboratory work for his patients and to small group practices which have laboratories providing limited laboratory services.

Each mailing will contain: (1) A whole blood specimen for a hemoglobin determination, (2) a lyophilized chemistry specimen for a glucose and BUN determination, and (3) a lyophilized urine specimen for specific gravity, protein, reducing substances, bile, and hemoglobin.

Cost of the 1969 testing packet is $45 and includes two mailings of specimens—one in September and the other in November.

Doctor Eilers explained that the office laboratory program will endeavor to insure high quality laboratory services to patients through interlaboratory evaluation, and "participation will demonstrate a physician's desire for quality laboratory work and the highest standards of patient care.

"It also will serve as an external quality control program," he said, "and assist the laboratory in evaluating currently used methodology and procedures. It will indicate outdated methodology and pinpoint the need for change through a list of corrective steps coded in the evaluation report."

For many years the CAP has been the leader in proficiency testing programs and now has the largest continuous survey programs in the world, according to Doctor Eilers.

Further information on the 1969 Office Laboratory Proficiency Evaluation Program may be obtained from the CAP, 230 N. Michigan Ave., Chicago, Ill. 60601. □

DIABETES DETECTION

Of 30,281 persons screened for diabetes in New Jersey during Diabetes Detection Week in November 1968, there were 3,551 with primary positive capillary blood sugar readings. Secondary testing of venous blood revealed 1,372 with positive readings. Physician diagnosis has confirmed 249 new diabetics, with reports on 570 patients still to come. The testing was carried out in 17 counties under the sponsorship of the state department of health.—*Diabetes Detection Newsletter, Vol. 2, No. 3 (August 1969)* □

NEW RESEARCH . . .

Propronolol: Reduced significantly the peripheral manifestations of thyrotoxicosis (a thyroid disease) in 16 patients. The dosage was 40 mg, 4 times daily for 1 week. Propranolol is available in the United States as Ayerst's Inderal. By Dr. R. G. Shanks and associates, Royal Victoria Hospital, Belfast, Ireland. —Reprinted from AMERICAN DRUGGIST, July 14, 1969 □

MINUTES OF COUNCIL MEETING

MILWAUKEE, MAY 11, 1969

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 2:05 p.m. on Sunday, May 11, 1969, at the Sheraton–Schroeder in Milwaukee.

Voting members present: Doctors Bayley, Schulz, Nordby, Stoops, Huth, Carey, McRoberts, Rohde, Boren, Ludwig, Manz, Houghton, Van Hecke, Egan, Sullivan, Chojnacki, Hollenbeck, Past President Kief, President James, and Speaker Behnke.

Officers and others present: President-elect Callan, Vice-speaker Nereim, Treasurer Weston; Doctors Bell, Bernhart, Galasinski, and Hildebrand, AMA delegates; Doctors Fox, Picard, Collentine, and Hill, alternates; Doctors Zawodny, Hamlin and Henken, reference committee chairmen; Doctors Evrard and Leonard for special order; Doctor Dessloch, chairman, Commission on Medical Care Plans; Mrs. James Sargent, President of the Woman's Auxiliary for special order.

Staff and consultants: Messrs. Crownhart, Thayer, Koenig, Reynolds, Brower, Maroney, McIntyre, LaBissoniere, Waldschmidt, Sandeen, Johnson, Miller, Possman, Murphy, Kluwin, Gill; Mrs. Anderson and Miss Pyre; also Mr. Weise, Secretary of PACE.

2. Approval of Minutes

On motion of Doctors Houghton–Ludwig, carried, minutes of the February meeting were approved.

3. Report by President

Doctor James reported on the trip of the Wisconsin delegation to Washington to attend the Congressional Dinner and visit individual Congressmen, and on recent actions of the Iowa Medical Society at its annual meeting.

4. Award to John R. Evrard, M.D.

Doctor Evrard announced his resignation as chairman of the Division on Maternal and Child Welfare to take further studies, and thanked members of the division for their work.

Doctor Leonard presented him with a lamp similar to those given by the Council to Doctors Kilkenny, Hofmeister, and Leonard for their long service with the maternal mortality studies. He hoped Doctor Evrard would return as a member of the division.

5. Commission on State Departments Elections

By separate motion duly made, seconded and carried, the general chairman, vice-chairman, and division chairmen were reelected, except that F. J. Hofmeister, M.D., was elected to succeed Doctor Evrard as chairman of the Division on Maternal and Child Welfare.

6. Report of the Treasurer

Doctor Weston presented his annual report on the general fund of the Society which is also made to the House of Delegates at the first session.

On motion of Doctor Egan, seconded and carried, the report was accepted.

7. Resolution on Family Life and Sex Education —Resolution I, 1969

Doctor Rohde discussed a resolution submitted after the deadline by the Trempealeau–Jackson–Buffalo counties medical society, and asked that it be forwarded to the House by the Council.

Following discussion, on motion made and amended, the resolution was forwarded with the recommendation of the Council in the following modified form, no changes in the introduction:

> *Resolved*, That the State Medical Society does approve of and encourage proper instruction in family life and sex education within the total (K-12) education of the child.

8. Resolution J of 1968

The Council received copy of action by the Council on Health in response to the Society's "Statement on Government Health Programs" and request for reconsideration of the position of the State on Resolution J of 1968.

On motion of Doctors Van Hecke–Kief, carried, the correspondence was accepted and placed on file, copy to be sent the Section on Pathology.

9. Report of Committee on Economic Medicine

Doctor Schulz reported that the committee had reviewed with Society insurance consultants the status of all Society-sponsored programs for members, and specifically recommended that the maximum monthly benefit under the disability insurance program be increased to $1,000. He said the committee is continuing its study of professional liability insurance.

The committee also reviewed a paper prepared by Mr. Thayer in response to a request for information by an individual who planned to publish an article on the Health Care Industry. This was entitled "Economic Analysis: The Health Care Industry in Wisconsin." The committee felt it was well documented and recommended that staff continue to cooperate in this activity.

On motion of Doctors Van Hecke–Huth, carried, the committee report was accepted.

On motion of Doctors Sullivan–Kief, carried, the Council thanked Doctor Schulz for his nine years of service on this committee.

10. Report of Finance Committee

Doctor Bayley reported that the committee had met in review of first quarter expenditures against the budget, and received a staff report on specific steps to reduce expenses where possible. He said the committee would be available for questions at the reference committee hearing.

Doctor Egan "as a minority member of the Finance Committee" asked for clarification of the scope of responsibility of the Finance Committee of the Council, stating his belief that it did not function as fully as it should. He also had questions about the WPS Charge Card Corporation which were held for later discussion.

Doctor Nordby said that by prior Council actions, the scope of responsibility of its Finance Committee has been limited to the general fund of the Society. The Council itself retains fiscal responsibility in other areas but has delegated responsibility for preparation of budgets and financial reports to the Commission on Medical Care Plans in the case of WPS and other health-care plans, and to the board of trustees of the SMS Realty Corporation, which bodies are held reportable to the Council.

On motion of Doctors Chojnacki–Carey, carried, the report of the Finance Committee was approved.

11. Woman's Auxiliary

Mrs. Sargent gave a report on activities and disposition of funds of the Auxiliary, both those allocated from Society dues and its own dues, during her tenure as President.

12. PACE

Doctor Kief presented a report on PACE as to membership, educational activities, and goals, and asked that the Councilors and Officers promote individual memberships as a civic responsibility.

13. Report of Executive Committee

Actions shown are by the Council upon recommendations of the Executive Committee on the following:

A. Wisconsin State Medical Assistants Society

On motion of Doctors Chojnacki–Ludwig, carried, the Council accepted appointment as advisors to the WSMAS of Drs. R. M. Baldwin, Beloit; C. E. Oberdorfer, Racine; and T. H. Peterson, Wausau.

B. Wisconsin Regional Medical Program, Inc.

On motion of Doctors Egan–Hollenbeck, carried, the Council reappointed Frank E. Drew, M.D., as the Society representative on the board of directors of WRMP for another year, and asked that he keep the Council fully informed.

C. School of Public Health

On motion of Doctors Kief–Sullivan, carried, the Council requested that the Commission on Health Information investigate the possibilities of starting a school of public health in one of the universities of the state at some future time.

D. Laboratory Licensing Legislation

On motion of Doctors Van Hecke–Sullivan, carried, the Council approved an addition to the laboratory licensing bill proposed by the Section on Pathology which would exempt from its terms those Wisconsin hospitals and blood banks which are subject by statute and regulation to the Division of Health and Department of Health and Social Services, so long as the standards of those statutes and regulations are comparable to those of the laboratory licensing law proposed in the bill of the pathologists.

E. Commercial Laboratories—Resolution J, 1969

On motion of Doctors Van Hecke–Schulz, carried, the Council forwarded to the House of Delegates a resolution relating to censorship of physicians who associate with commercial laboratories in an unethical manner.

Doctor Van Hecke also suggested that the availability of pathology services in the state be published again pursuant to action in 1957.

F. Medical Education

On motion of Doctors Chojnacki–Ludwig, carried, the Council reaffirmed the previously stated position of the Society to encourage an increase in enrollment at both medical schools in the state and eventual creation of a third medical school; and further, that the matter of location of an expanded or new school is the responsibility of the Board of Regents.

G. Executive Vice-president of AMA

On motion of Doctors McRoberts–Schulz, carried, the Council made an advisory recommendation to the Wisconsin AMA delegation that it reintroduce a resolution allowing the Executive Vice-president of the AMA the privilege of addressing its House of Delegates annually.

H. Scientific Section Membership Qualifications

On motion of Doctors Sullivan–Van Hecke, carried, the Council approved membership qualifications proposed by the Section on Surgery:

(1) Those completing three years of accredited surgical training after internship;
(2) Chiefs of Departments of Surgery of accredited hospitals during their term in office;
(3) Requirements concerning postgraduate training will be waived in the case of graduates prior to 1940, who devote 75% of their practice to surgery.

It also agreed that membership qualifications for all the scientific sections be worked out with the individual sections rather than through the mechanism of an ad hoc committee which had proved to be unsuccessful.

I. Resolution C, 1969

On motion of Doctors Sullivan–Kief, carried, the Council recorded its disapproval of the resolution by the Dodge County Medical Society to permit membership in a county medical society only.

J. 1969 Work Week of Health

The Council accepted information that the week of October 6–10 has been scheduled, with programs in Eau Claire, Wausau, Green Bay, Milwaukee, and Madison on subjects of special interest to youth.

K. University of Wisconsin Family Medicine Club

The Executive Committee considered a proposal for the summer employment of freshman medical students by general practitioners in the state, and a request for Society financial support of such a program. A grant application was also being made to the Sears Foundation.

The committee recommended that they be given advice and encouragement in arranging a meaningful experience, but that the financing is not possible in the Society budget.

On motion of Doctors Kief–Chojnacki, carried, the Council requested that the chairman appoint a committee to investigate the possibility of the two Wisconsin Blue Shield plans, or other sources, funding this project through the Foundation for about $6,000 a year.

Doctor Nordby appointed Doctors Kief, Rohde, and Hollenbeck, who were asked to report back to the Executive Committee.

L. George W. Hilliard, M.D.

On motion of Doctors Hollenbeck–Ludwig, carried, the Council expressed support of the recommendation of the Commission on Hospital Relations and Medical Education to establish in the Foundation a postbaccalaureate fellowship bearing the name of George W. Hilliard, M.D.

M. Wisconsin Veterinary Medical Association

On motion of Doctors Egan–Manz, carried, the Council approved action of the committee in communicating its support of efforts of this association to establish a college of veterinary medicine in the state.

N. The Academy of Medical History

On motion of Doctors Chojnacki–Egan, carried, the Council approved a recommended bylaw amendment to change the name of the Section on Medical History to The Academy of Medical History to lend more status to this activity.

O. MDs Like It Here

Members of the Council received a lapel button and a description of the campaign using this theme to bring and keep physicians in Wisconsin.

P. Building Needs

Mr. Thayer advised the Council that in consultation with the Executive Committee, planning has begun with the architects, city planners, and others to consolidate operations in a building addition on Society-owned property.

14. Supplementary Report of Commission on Medical Care Plans

Doctor Dessloch reviewed the status of the postpayment plan as developed through the WPS Charge Card Corporation since reporting to the Council last July. A written report was also distributed.

Some questions were raised in discussion regarding this organization and the chairman indicated that time would be allotted on the next agenda for further discussion.

On motion of Doctors Ludwig–Bayley, carried, the supplementary report of the Commission was approved.

15. Councilor District Reports

There were reports by individual councilors on general conditions in their districts. No situation was presented requiring the attention of the Council. Doctor McRoberts suggested that delegate caucuses be held prior to annual meetings when there was particular reason to and not routinely each year.

16. Annual Report on Conflict of Interest

The Secretary reported that all those required to file a certificate on conflict of interest have done so.

17. Student Loan Fund—Resolution K, 1969

On motion of Doctors Van Hecke–Hollenbeck, carried, the Council forwarded a resolution to the House indicating the urgent need for additional contributions to the Foundation for student loans.

18. Thanks to Retiring Councilors

On motion of Doctor McRoberts, carried by acclamation, the Council spread on its minutes a vote of appreciation for the work of the retiring members of the Council.

19. Adjournment—5:30 p.m.

C. H. Crownhart
Secretary

Approved:
E. J. Nordby, M.D.
Chairman

MINUTES OF COUNCIL MEETING

MILWAUKEE, MAY 14, 1969

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 11:35 a.m. on Wednesday, May 14, 1969, at the Sheraton–Schroeder in Milwaukee, following adjournment of the House of Delegates.

Voting members present: Doctors Nordby, Smejkal, Mauthe, Dettmann, Boren, Ludwig, Manz, Houghton, Foley, Egan, Sullivan, Hollenbeck, Past President James, President Callan, and Speaker Behnke.

Officers and others present: President-elect McRoberts; Messrs. Crownhart, Thayer, Koenig, Maroney, Johnson, Possman, Kluwin, Murphy, Gill; Mrs. Anderson and Miss Pyre.

2. Election of Officers

By separate motion duly made, seconded and carried, the following were reelected for the ensuing year:

A. Chairman of the Council: E. J. Nordby, M.D.
B. Vice-chairman of the Council: J. M. Sullivan, M.D.
C. Treasurer of the Society: F. L. Weston, M.D.
D. Assistant Treasurers: H. Kent Tenney, M.D.
N. A. Hill, M. D.
J. T. Sprague, M. D.
R. A. Sievert, M.D.
E. Editorial Director, *Wisconsin Medical Journal:* D. N. Goldstein, M.D.

3. Oath of Office

The oath of office was administered by the Chairman to J. W. McRoberts, M.D., President-elect, and to W. F. Smejkal, M.D., Howard Mauthe, M.D., and T. J. Foley, M.D., district councilors.

4. Organization of the State Medical Society

The Chairman announced that because several newly elected councilors were not able to be present, the presentation on organization of the Society and affiliates would be postponed.

5. Federal Health Legislation

Mr. Kluwin reviewed the inquiry received from Senator Nelson in reference to 17 existing federal health programs which will be considered by the Health Subcommittee of the Senate Labor and Public Welfare Committee, and research done since receipt of the inquiry by Messrs. Maroney and McIntyre. He reported contact with the Senator's office to determine what other sources in Wisconsin had received the inquiry, how soon the information was needed, etc.

Mr. Kluwin recommended that the material be returned to the staff and consultants for further study and preparation of a report to be cleared with the Executive Committee of the Council.

On motion of Doctor Sullivan, seconded and carried, this recommendation was accepted.

6. Council Committee Assignments

Chairman Nordby said he would advise all councilors of their committee assignments, and announced appointment of the following as chairmen of Council committees, who also serve on the Executive Committee:

Economic Medicine: J. M. Sullivan, M.D.
Scientific Medicine: W. J. Houghton, M.D.
Planning: Walton R. Manz, M.D.
Finance: J. E. Dettmann, M.D.

7. Adjournment—11:55 a.m.

C. H. Crownhart
Secretary

Approved:
E. J. Nordby, M.D.
Chairman

★

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WISCONSIN MEDICAL JOURNAL
Vol. 68, No. 9 SEPTEMBER 1969

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Society Acts as "Friend of the Court" to Support Public Funds for Marquette

Appearing as a "friend of the court," the State Medical Society of Wisconsin presented a lengthy brief before the Supreme Court of Wisconsin in support of the continuation of Marquette School of Medicine with public funds.

At a hearing before the court on September 3, the Society argued that:

1. State law calls for a disbursement of public funds for public purposes and that the use of public funds for Marquette School of Medicine is a fulfillment of two governmental functions of first rank, namely those of education and the preservation of public health.
2. Unless Marquette School of Medicine receives state funds, it can not continue to operate. If Marquette should be forced to close, this would mean the permanent loss of any further additions to the physician resources of the state from its now second medical school.
3. A growing number of states have found it possible to appropriate public funds to non-public medical schools.

The Society's petition recited at length interest of the State Society in the preservation and expansion of Marquette School of Medicine, its appeal to the Governor's Task Force on Medical Education to maintain Marquette School of Medicine, and the interest of the House of Delegates and the Council in providing support to aid the continued operation of the school with state funds.

The court also heard opposing argument that state appropriations were not valid for Marquette School of Medicine because "no public purpose exists in the absence of direct and immediate benefit to the public." Those opposing the appropriation said any benefits from public appropriations were "speculative, indirect and extremely remote."

The Society's brief also recited recent Society activities in taking paid advertisements in the major daily newspapers of Wisconsin to inform the public of the financial crisis of Marquette School of Medicine and the need for operating funds to be raised on a month-to-month basis. The Society pointed out to the court that graduates of Marquette School of Medicine are now practicing in every corner of Wisconsin. An exhibit was presented to the court showing that 1407 physicians practicing in Wisconsin are graduates of Marquette and they practice in 188 different cities.

The brief also noted that state support of private medical schools has been given in Florida, Pennsylvania, North Carolina, Ohio and New York.

Rep. Steiger Appeals for Health Planning

Laws barring "the best use of available personnel" were attacked recently by Rep. Wm. A. Steiger, 6th District, Appleton, at a "Doctors for Plymouth" recognition dinner.

Recalling the case of the Sheboygan County village of Adell, Rep. Steiger asked for increased health care planning among the medical profession, government and citizens to assure adequate health care for all communities.

"Unless we all get busy planning for the health care and service needed in the years ahead, similar situations like the one that occurred in the village of Adell are going to occur again in larger communities," he said.

Adell, without a doctor for 3½ years, recently obtained a Philippino physician, Dr. Jose Q. Tolentino. Considerable publicity was attracted to him because he had difficulty as an alien obtaining a license to practice in Wisconsin. Governor Knowles signed a bill in April allowing him to practice medicine while his application for citizenship was pending.

The State Medical Society has asked the State Legislature to amend existing laws so that alien physicians may practice medicine before they have actually applied for citizenship. Basic standards for medical education are retained in the proposal.

Expect Million to See Work Week of Health Drug Program on Television, October 6–9

Almost the entire state of Wisconsin can be "in the audience" for the 1969 Wisconsin Work Week of Health, October 6–9.

When the 7th Annual Work Week begins on Monday, October 6, in Eau Claire, anyone with access to a TV set can be a participant.

For the first time in its history, the Work Week will be presented entirely on television. Through the generous cooperation of the Wisconsin television industry, this year's Work Week will come "live" to a major portion of the state, and video-taped to the remainder.

In response to popular demand by students, educators, parents and interested members of the public, the 1969 Work Week will be devoted to "The Drug Turn On."

In the course of the four days, six television stations will present live broadcasts of the drug program. Each station will present from two to two-and-one-half hours of programming originating in a studio with a live audience.

Featured on the program will be David E. Smith, M.D., medical director of the Haight–Ashbury Medical Clinic in San Francisco, and two young ex-addicts or heavy users from Encounter, Inc. in New York City.

Television stations taking part in the program will be:

WEAU-TV, Channel 13—Eau Claire, 9:00 a.m. to 11:30 a.m., Monday, October 6.

WKOW-TV, Channel 27, Madison, and WAOW-TV, Channel 9, Wausau, 9:30 a.m. to 11:30 a.m., Tuesday, October 7.

WFRV-TV, Channel 5, Green Bay, and WMJN-TV, Channel 3, Escanaba, Mich., 9:00 a.m. to 11:30 a.m., Wednesday, October 8.

Other TV stations in the state are currently scheduling video-tape replays of one or the other of the above programs.

Details of the programs on each station are shown in accompanying columns.

Dr. Robert E. Callan, Milwaukee, president of the State Medical Society, declared the joint effort of medicine and the television industry as one of the "great breakthroughs" in public service activity for educational purposes.

Although the Work Week in 1969 is being broadcast primarily to reach the school age youth of Wisconsin in the 7th through 12th grades, the use of television means "that every interested citizen can become part of the program by a flip of the wrist."

"There are nearly 509,000 Wisconsin students in grades 7 through 12," Doctor Callan pointed out. "Virtually every one of them will be able to see the Work Week program on drugs via one of the television stations taking part in the week."

"On top of this, there is an enormous fringe audience of adults who will be able to tune in the 'Turn On' along with the teenagers," Doctor Callan notes.

The entire television series will be supplemented with study guides, teacher resource material and student reading matter distributed in advance to all public and private junior and senior high schools.

Will You Help?

This is a call to physicians and their wives to help the 1969 Wisconsin Work Week of Health win an "Emmy" for the state's television stations.

The TV stations taking part in presenting the Work Week program entitled "The Drug Turn On" seek to have every Wisconsin high school and junior high school pick up the live broadcasts for viewing by grade 7–12 students.

You can help by contacting your local school system to offer assistance in providing TV sets if needed.

You can help by publicizing the program on the station nearest you . . . to schools, civic groups, churches, clubs and organizations of all kinds . . . and to your neighbors.

You can help just by watching . . . and then writing to the SMS, Box 1109, Madison, Wisconsin 53701 to tell what you thought of the whole program.

THURSDAY, OCTOBER 9

(Latest scheduling)

WTMJ-TV, Channel 4

Milwaukee

9:00 a.m. to 9:30 a.m.

An interview with Dr. David Smith, the Encounter teenagers, and Dr. Robert E. Callan.

WDIO-TV, Channel 10

Duluth

9:30 a.m. to 11:00 a.m.

A video replay of the Wednesday program from Green Bay (see page 41).

WKBT-TV, Channel 8

La Crosse

9:30 a.m. to 11:00 a.m.

A video replay of the Monday program from Eau Claire (see page 41).

(Other stations pending)

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EDITOR: Earl R. Thayer, Director of Socio–Economic Medicine.

MONDAY, OCTOBER 6

WEAU-TV, Channel 13

Eau Claire

9:00 a.m. to 11:30 a.m.

Introduction by Dr. Robert E. Callan, Milwaukee, President, State Medical Society of Wisconsin.

Remarks by the Governor, Wisconsin Boy's State

"LSD and Other Many Splendored Things"
David E. Smith, M.D.
Medical Director, Haight–Ashbury Medical Clinic
San Francisco

"Escape to Nowhere"—the drug turn-on as viewed through the eyes of a young girl involved in the drug scene.

"How to Kick the Habit"
Two ex-addicts tell their teenage stories, in person—and how they got help through Encounter, Inc.

"The Speed Scene"—a look inside the "speed subculture" and the dangers of amphetamine abuse.

"Are Sideburns Dangerous"—a give-and-take discussion between Doctor Smith, the Encounter members and the studio audience of teenagers on such subjects as keeping on (or off) the grass, how to be one of the beautiful people, and some of the health hazards of hippie living.

TUESDAY, OCTOBER 7

WKOW-TV, Channel 27

Madison

and

WAOW-TV, Channel 9

Wausau

9:00 a.m. to 11:00 a.m.

Introduction by Dr. Robert E. Callan, Milwaukee, President, State Medical Society of Wisconsin.

Remarks by the President, Wisconsin Youth Committee

"LSD and Other Many Splendored Things"
David E. Smith, M.D.
Medical Director, Haight–Ashbury Medical Clinic
San Francisco

"How to Kick the Habit"
Two ex-addicts or heavy users tell the story of their teen-age years—in person—and how Encounter, Inc. gave them a lift.

"The Speed Scene"—an inside view of the "speed subculture" and the dangers of amphetamine abuse.

"Are Sideburns Dangerous"—a give-and-take discussion involving Doctor Smith, the two Encounter members and the studio audience of teen-agers on such subjects as keeping on (or off) the grass, how to be one of the beautiful people, and some of the health hazards of hippie living.

WEDNESDAY, OCTOBER 8

WFRV-TV, Channel 5

Green Bay

and

WMJN-TV, Channel 3

Escanaba

9:00 a.m. to 11:30 a.m.

Introduction by Dr. Robert E. Callan, Milwaukee, President, State Medical Society of Wisconsin.

Moderator: Dr. Robert Schmidt, Green Bay, President of the Brown County Medical Society

"Drugs and the Nervous System"—Information and misinformation on drug use and abuse.

"LSD and Other Many Splendored Things"
David E. Smith, M.D.
Medical Director, Haight–Ashbury Medical Clinic
San Francisco

and

Two teen-age ex-addicts (or heavy users) tell their personal stories of how they "kicked the habit."

"Fight or Flight"—a teen-ager takes a good look at both the soft and the hard stuff.

"Are Sideburns Dangerous"—a give-and-take discussion involving Doctor Smith, the teen-age ex-addicts, and the studio audience of Northeastern Wisconsin youth.

Teaching Aids to Help Schools and Students on Drug Abuse

More than 900 junior and senior high schools in Wisconsin, both public and private, will receive advance mailings of printed material to assist them in making the most of the Work Week of Health TV series on "The Drug Turn On."

About mid-September each school will receive a packet containing:

. . . Two copies of "Guidelines for Drug Programs" outlining teaching techniques for inservice programs and classroom activities. This has been prepared by the National Institute of Mental Health.

. . . Two copies of a list of films, tape recordings, and literature relating to the use and abuse of drugs, and instructions on how these may be obtained.

. . . Two copies of "Drug Abuse: The Chemical Cop-Out," a publication of the National Association of Blue Shield Plans, and one of the outstanding booklets available for basic understanding of dangerous drugs and narcotics.

. . . Sufficient copies of the 1969 Work Week program for each student in each junior and senior high school.

. . . Copies of a Wisconsin Blue Shield leaflet summarizing essential information about marijuana, LSD, barbiturates, amphetamines, and glue sniffing.

School officials will be urged to organize special teaching efforts to coordinate with the Work Week television programs each morning, Monday–Thursday, October 6–9.

November 13 at SMS

The State Medical Society's Division on Nervous and Mental Diseases will conduct a symposium at Society headquarters in Madison Nov. 13. Chairman of the Division is Dr. E. E. Houfek, Sheboygan.

URGE PHYSICIAN MEMBERSHIP . . .

Wisconsin Association of Professions Grows

The Wisconsin Association of the Professions has launched a program to enlist support from individual members of the professions of architecture, law, medicine, education, pharmacy, engineering, dentistry, veterinary medicine and certified public accounting.

Several Wisconsin physicians, members of the State Medical Society, are taking leading roles in the development of the Association known as WAP.

Dr. Nels A. Hill, Madison, and Dr. S. W. Hollenbeck, Milwaukee, are members of the WAP Board of Directors.

Officers are R. J. LeBosquet, Madison, professional engineer, president; Wm. J. O'Rourke, Madison, veterinarian, vice president; Vere L. Fiedler, Madison, professional engineer, secretary; and F. B. Henderson, Stoughton, dentist, treasurer.

According to President LeBosquet, WAP was created to provide the organizational machinery whereby the combined strength and counsel of all professions "can be utilized for the advancement of professional ideals and the promotion of professional welfare. This should strengthen the traditional rights, privileges, and responsibilities of each profession. At the same time it should also provide more effectively to the people adequate professional services based on skill and integrity." LeBosquet said that close relationships between members of the professions place them in a better position to be "molders of public policy."

WAP will devise ways and means of better utilizing the professional knowledge and skills of its members for the benefit of society and attempt to create the kind of relations between professions which will most effectively accomplish this objective.

LeBosquet said that WAP is not a political organization. "It is nonpartisan." But, he added, it will serve its members as one practical medium of communication between the professions and legislative bodies.

WAP will not replace professional societies nor will it compete with them or duplicate their efforts. For example, the transfer of licensing and regulation of professionals to the Board of Licensing and Regulation has created some problems. The WAP Legislative Advisory Committee has appeared before legislative committees to object to the method of budget control over professional licensing and regulating boards.

In another situation, WAP has appealed to the University of Wisconsin and the State Universities to appoint registered licensed professionals as chairmen or deans of schools or colleges whose responsibility is to graduate such professionals.

The WAP is governed by a Board of Directors made up of two representatives of each of the nine professional societies in Wisconsin plus directors at large.

Annual dues for an individual member in WAP are $10. Members in good standing of their state professional organization are automatically qualified for individual membership. Applications for physician membership may be sent to the State Medical Society of Wisconsin, Box 1109, Madison 53701 for processing.

The professional societies which are members of WAP are: Wisconsin Chapter of the American Institute of Architects, State Bar of Wisconsin, State Medical Society of Wisconsin, Wisconsin Education Association, Wisconsin Pharmaceutical Association, Wisconsin Society of Professional Engineers, Wisconsin State Dental Society, Wisconsin Veterinary Medical Association, and Wisconsin Society of Certified Public Accountants.

For Loan to medical students: Seven microscopes in excellent working condition. No charge. Contact the CES Foundation of the State Medical Society, Box 1109, Madison, Wis.

That's right! A microscope loan program for deserving medical students. Another CES Foundation project.

The loan program is the Foundation's answer to the special hardship that purchase or rental of a microscope imposes on the medical student who has stretched his finances to the limit.

To date, seven microscopes have been acquired by the Foundation through the generosity of physicians:

James P. Conway, MD, Milwaukee
A. H. Heidner, MD, West Bend
Ludwig Schoen, MD, Wausau
L. W. Nowak, MD, Watertown
L. J. Friend, MD, Beloit
L. A. Moore, MD, Monroe
F. G. Johnson, MD, Superior

And, incidentally, the demand exceeds the supply. Anyone feel like donating an optically and mechanically usable microscope?

New Officers on Health-Social Services Board

Franklin Walsh, Walworth County dairyman and former county board chairman, is the new chairman of the state board of health and social services.

He and other new officers of the board were installed September 10.

Vice chairman of the board is Arthur P. Schmidt, Hartland, director of community relations for Schlitz brewery.

Mrs. John McCarrier, Wausau, a housewife and child welfare chairman of the Wisconsin Council of Catholic Women, was chosen to follow Dr. Frank Drew, Milwaukee, as secretary. Dr. Drew resigned from the board in August. He had served since 1967.

WISCONSIN DOCTORS CAMPAIGN to ease the doctor shortage—throughout the July meeting of the American Medical Association meeting in New York. Wisconsin physicians attending the session wore lapel buttons entitled, "MDs Like It Here," and utilized the Wisconsin headquarters to display a flag embroidered with the same appeal. Shown with the flag are: (l–r) Drs. C. J. Picard, Superior; R. E. Galasinski, Milwaukee; E. L. Bernhart, Milwaukee; D. J. Carlson, Milwaukee; and T. J. Nereim, Madison. The flag was designed and made by Mrs. Sally Hegley, Baraboo, daughter of SMS Secretary, C. H. Crownhart.

SOCIETY BOASTS "MDs LIKE IT HERE"

"Wonderful Wisconsin Week" will be celebrated this year from Sunday, September 21 to Saturday, September 27 with the State Medical Society as one of the cooperating groups.

The seven-day salute has four purposes:

1. To call attention to Wisconsin's citizens and Wisconsin's assets;
2. To offer our own people a greater knowledge, pride, and appreciation of this state;
3. To use the spirit of the Week to generate greater citizen involvement in community affairs; and
4. To add another exciter to the state's economic dynamo, helping sell Wisconsin throughout the nation.

The theme of the week-long event is the now famous slogan, "We Like It Here."

The State Medical Society has picked up the theme in its efforts to entice doctors to practice in Wisconsin with a promotional campaign entitled, "MDs Like It Here." The campaign involves appeals to medical students, interns and residents as well as physicians from other states who make inquiry about locating in Wisconsin.

The Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien, operated by the Charitable, Educational and Scientific Foundation of the State Medical Society, will take advantage of Heritage Day on Sunday, September 21, to hold an open house for visitors in the area. Throughout the state, emphasis will be on Wisconsin's history and its spiritual foundations.

WORK WEEK OF HEALTH MARKS ITS 7th YEAR

October 6–9, 1969 will mark the Seventh Annual Wisconsin Work Week of Health under the sponsorship of the State Medical Society of Wisconsin.

When the Society was formed in 1841, it mandated the medical profession to "enlighten and direct public opinion in regard to the great problems of state medicine."

This philosophy prompted the establishment of the Work Week of Health in 1963. Dr. N. A. Hill, Madison, then President of the Society, pointed out that the goal of the Work Week of Health was to "provide a forum for the exchange of information on the health status of our state and to communicate this information to the public."

He added: "It behooves us periodically to take stock of our health . . . areas which need special attention, and people who have special problems. . . ."

He said: "We do not expect to solve problems in a few days. But your participation, and thoughts and actions following the events of the Wisconsin Work Week of Health, will be of great significance in the eventual solution of any problems we may have."

It is because problems of drug abuse continue to grow so rapidly in Wisconsin that the Society, the television and other cooperating industries in the state have decided to focus the attention of the 1969 Work Week entirely on drug abuse and narcotic addiction.

SMS President Named to Regional Planning Post

Dr. Robert E. Callan, Milwaukee, president of the State Medical Society, has been appointed to the Regional Advisory Committee of the Wisconsin Regional Medical Program.

The committee represents a broad cross section of the state's population and has a major role to play in the continuing development of the Program in Wisconsin.

LEGISLATIVE HOT LINE

IMPORTANT DEADLINE: SEPTEMBER 29—The State Legislature returns for a week-long special session called for by Governor Knowles to deal with "special problems of urban areas." The Governor has specifically named financial aid to Marquette School of Medicine, initiation of a comprehensive community mental health program and assistance for the medically indigent under Medicaid as items with which this special session is to deal. On October 7, the Legislature resumes its regular business. Physicians are urged to contact their State Assemblymen and Senators on issues of concern to them between now and September 29.

MEDICAL EDUCATION FUNDS—The approved budget for 1969-71 biennium, signed by Governor Knowles, provides $1,310,000 for advance planning for the University of Wisconsin Medical Center. A trailer budget proposal, which passed the Senate but not the Assembly, would provide $3.2 million in aid for Marquette School of Medicine. The special session will likewise consider a multimillion dollar aid bill for Marquette pending outcome of the Court test of the use of public funds for the school.

CHIROPRACTIC—Attempts are still being made to include payment for chiropractic services under Medicaid (Bill 97A) and Workmen's Compensation (Bill 307A). SMS opposes both bills.

SCHOOL ATTENDANCE—Senate Bill 372 would provide that before a school board may exempt a child from school attendance because of his physical or mental conditions he must obtain a physician's certificate as to his conditions. The Society supports passage of this legislation in its present form.

DRUG ABUSE CONTROL—The Society supports Assembly Bill 585 which would provide that any person who attempts to or does obtain a dangerous drug by fraud or misrepresentation shall, upon first conviction, be imprisoned not more than one year or fined not more than $500 or both. The Society also supports Assembly Bill 700 which would prohibit the sale of toxic glue to persons under 21.

LABORATORY LICENSING—Bill 548S is a proposal by a Wisconsin group of medical technologists to license all types of laboratory personnel. State Medical Society backed amendments to this bill are being submitted to license laboratories and their directors rather than the individual personnel.

MEDICAL PRACTICE AMENDMENTS—Amendments aimed at updating current medical practice regulations as embodied in Bill 583S are to be the subject of a hearing before the Senate Public Welfare Committee in the near future. Additionally, both this legislation and Assembly Bill 1018 would eliminate the present statutory requirement that immigrant applicants for permanent licensure "present satisfactory evidence that he has filed a declaration of intention to become a citizen of the United States." Governor Knowles and members of the Society's Ad Hoc Committee on the Medical Practice Act both support this change which is designed to help meet the physician shortage problem.

MEDICAL EXAMINER SYSTEM—The Senate has passed Joint Resolution 63 which would allow a county or group of counties to adopt a medical examiner system in lieu of the present constitutional requirement for a coroner. This bill, which is on the Assembly calendar, was offered at the request of the State Medical Society and has been given specific support by the House of Delegates.

PSYCHOLOGY LEGISLATION—The Assembly has passed legislation which would license psychologists. The Society continues to oppose this legislation in its present format, and its offers to jointly work out this proposal have not been accepted by the psychologists urging Bill 20A.

IMPLIED CONSENT—The Governor's proposal for blood alcohol tests for individuals suspected of driving while under the influence of alcohol has passed the Senate (Bill 219S). It includes a provision which would grant immunity to physicians who are performing the required tests. The Society supports this legislation as well as Assembly Bill 1021 which would also provide immunity to a physician or a person acting under the physician's direction while performing such tests.

SHORTAGE OF PROFESSIONAL PERSONNEL—The Society is supporting Senate Joint Resolution 74 which would authorize the Legislative Council to study the shortage and need for more dentists, doctors, surveyors, and other professional skills in the State of Wisconsin.

HEARING AID DEALERS—The Society is opposing legislation which would license hearing aid dealers. Assembly Bill 391 would create a hearing aid dealers and fitters examining board in the Department of Regulation and Licensing. It is the position of the Society's Division on Ear, Nose and Throat that the legislation, as it is now worded, would create mass confusion for the general public as to the actual ability and legitimate scope of activities of those who sell hearing aids.

DISPENSING OPTICIANS BILL—Society-supported legislation for the certification of dispensing opticians under the Medical Examining Board is under consideration by the Senate (Bill 469S). Proper regulation of this ancillary group with medical involvement will serve the health interest of all Wisconsin citizens.

THE GOVERNOR'S VETO of certain parts of the 1969-71 Budget Bill has impact on several health areas.

. . . The Governor vetoed a proposal that fee schedules for Medicaid services (physicians, dentists, etc.) be negotiated by individual county welfare directors with providers instead of statewide.

. . . The Governor vetoed a plan to limit free choice of physician and dentist under Medicaid. He did not veto some limitation on free choice of nursing home.

. . . The Governor did not veto a section of the bill which seeks to restrain fee increases to the May 1, 1969 level, and in any event limits increases to 4½% per year until July 1, 1971.

231,320 Persons Complete Medical Self-Help Training

Medical Self-Help training has been completed by 231,320 persons in Wisconsin as of May 1, 1969, according to a report issued by the State Division of Health.

James Joyce, coordinator for the program, said that those completing the training have had approximately 16 hours of classroom work using instructional materials prepared by the United States Public Health Service. The course was designed to give each trainee the knowledge and ability to handle many medical emergency situations if disaster struck and professional help was likely to be delayed.

Joyce said that the emergency self-help programs that started up after World War II were civil defense oriented, but that the current program is geared more to natural disasters such as tornadoes, floods, fires, explosions, and similar threats.

The program, beginning in Wisconsin in 1963, has had 6,737 separate sessions through April of this year. Generally it has been taught by volunteer instructors in high schools, vocational schools, nursing schools, the state university system, the university extension system, in fire and police departments, and in private industry.

131 COMMUNITIES SEEK PHYSICIANS

Looking for a place to practice in Wisconsin?

That's easy.

There are 131 different communities in Wisconsin which are listed by the State Medical Society's placement service as desiring physicians. In fact, these towns are looking for a total of at least 154 doctors.

The Wisconsin placement service is tied into a nationwide doctor-seeking network operated by the AMA and the medical schools.

Dr. Robert E. Callan, Milwaukee, president of the State Medical Society, reports that "forty of these requests are from towns of 3,000 population or less. These are the same towns which seek dentists, lawyers, and other services."

"Our Placement Service has helped to find hundreds of doctors for various communities over the years," he said, "but I must be candid to say that these small communities suffer intense competition for the small pool of doctors available."

Maternity Course Offered Nurses

Marquette University College of Nursing is offering a two-week Advanced Maternity Program in Delivery Room Nursing for graduate nurses.

The program is designed for nurses presently employed in hospitals, or as a refresher program for those graduate nurses who anticipate returning to work in a maternity department.

Beginning dates are Oct. 13 and Nov. 10, 1969; Jan. 12, Feb. 16, Mar. 9, and Apr. 6, 1970.

The session beginning Jan. 12 will last three weeks. The extra week will be spent in clinical practice and is designed for recent graduates.

Applications or inquiries should be directed to: Miss Lois Olsen, RN, Marquette University College of Nursing, 3029 N. 49th St., Milwaukee 53210.

Identical Twins Needed

The Medical Genetics Center, UW, Madison, is seeking identical twins over 10 years old to give blood for lab experiments. Contact Dr. Fritz Bach at (608) 262–6571.

Ask Help of MDs in Use of Consultant on Workmen's Comp Cases

The use of consultants by physicians caring for patients whose cases are under Workmen's Compensation involves certain obligations of which many physicians may be unaware.

This situation was brought to light by recent reports from Workmen's Compensation insurance carriers who indicate that some physicians fail to discuss with the carrier their plans to refer patients to consultants.

Listing of the physician on the "Open Panel" carries with it certain obligations on all parties. With regard to consultation, the principles state that:

"It is a basic principle of the Open Panel Program that consultation can be requested by either the attending physician, the insurance carrier, the employer, or the employee. It is essential that the request for consultation be known to the other parties immediately concerned. Also, the selection of the consultant should be mutually acceptable to both the attending physician, and the insurance carrier or the employer."

Further elaboration of this principle and matters concerning reports, complaints, free choice of physician and changing physicians are outlined in the State Medical Society's January 1969 Blue Book Issue of the WISCONSIN MEDICAL JOURNAL on pages 29–30.

James Varnum Named Supt., Univ. Hosps.

James W. Varnum of Madison has been named superintendent of University of Wisconsin Hospitals succeeding Edward J. Connors, who has been named superintendent of the University of Michigan Hospital.

Approval by the board of regents followed a recommendation of Dr. Peter L. Eichman, director of the UW Medical Center. The appointment became effective Sept. 1.

NEWS HIGHLIGHTS

La Crosse Clinics to Merge October 1

Announcement has been made of the merger of the Grandview and Skemp clinics in La Crosse.

The Grandview Hospital and Clinic, a 63-bed facility established in 1916, will discontinue operations October 1 when the clinics merge.

A member of the clinic staff, Dr. Robert L. Gilbert,* explained that he considered it unrealistic to expect a small hospital such as Grandview to undertake a major expansion program, in view of large medical facilities at St. Francis and Lutheran hospitals, plus shortages of qualified personnel now existing.

It was believed that most of the hospital's staff would be picked up by the other hospitals who also have personnel shortages.

The Skemp Clinic recently completed a new unit to its facilities and the newly merged operation will be known as the Skemp–Grandview Clinic. It accommodates 16 doctors.

Dr. S. E. Sivertson Named Assistant Coordinator, Regional Medical Program

The Wisconsin Regional Medical Program (WRMP) recently announced the appointment of Dr. Sigurd E. Sivertson* as assistant coordinator for WRMP.

The appointment became effective August 1. Doctor Sivertson is associate chairman of the Department of Postgraduate Medical Education and assistant clinical professor of medicine, University of Wisconsin Medical Center, Madison.

Doctor Sivertson is a graduate of the University of Wisconsin Medical School and interned at St. Luke's Hospital, Duluth, Minn. He then completed a fellowship at the Mayo Clinic, Rochester, Minn., and joined the Gundersen Clinic in La Crosse as a specialist in internal medicine. He later was named director of medical education and research for the Adolph Gundersen Medical Foundation and Gundersen Clinic in La Crosse Lutheran Hospital.

Also named an assistant coordinator was Peter J. Sheldon of Marquette School of Medicine. He is an assistant professor of sociology in the Department of Preventive Medicine.

As assistant coordinators, they will be responsible for all liaison between WRMP and their respective medical facility. This includes WRMP funding as well as project programing.

Scientific Exhibit Cited in New York

An exhibit that won two awards at the State Medical Society's annual meeting in May 1968 was given honorable mention at the annual meeting of the American Medical Association in New York City this July.

The scientific exhibit, "Ulcers in Childhood," was presented by Drs. Margaret Prouty* and Dorothy Oakley* of the pediatrics department, Jackson Clinic, Madison. The award was presented by the AMA's Section on Pediatrics.

In the state showing, the exhibit was named "Best in the Show" and also received the Mead–Johnson Aesculapius Award.

Dells Area Has Extra Doctor

A special bill authored by Lt. Gov. Jack Olson was signed into law earlier this summer to enable Dr. Daniel Beebe of Melbourne, Australia, to practice surgery and medicine in the Wisconsin Dells area for the four-month tourist season there. He is employed at the Dells Clinic.

PHYSICIAN BRIEFS

Dr. Ernest C. Deeds*

. . . Janesville, has joined the staff of the Pember–Nuzum Clinic as a member of the department of internal medicine. Doctor Deeds graduated from Marquette School of Medicine and completed a three-year residency at Milwaukee County Hospital. He served a tour of duty with the United States Medical Corps, Ft. Lewis, Wash.

Dr. L. O. Simenstad*

. . . Osceola, a trustee of the American Medical Association, has been traveling this summer attending medical meetings and points of interest. In June Doctor and Mrs. Simenstad and Betsy visited England, Norway, and Denmark, and thence to Paris where Doctor Simenstad was a delegate to the World Medical Association. And in July Doctor and Mrs. Simenstad were in New York City and Boston where they attended meetings of the American Medical Association and the World Health Organization.

Dr. Lawrence J. Mervis

. . . Milwaukee, recently completed his military tour of duty at the Naval Hospital in Bethesda, Md., and has joined Marquette School of Medicine faculty having been appointed assistant professor of neurosurgery.

Dr. Robert M. Baker*

. . . Madison, recently joined the staff of Associated Physicians in the practice of Obstetrics–Gynecology. He graduated from the University of Minnesota Medical School, served his internship at Santa Clara County Hospital, San Jose, Calif., served two years

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

of active duty with the United States Navy and completed his residency at the University of Wisconsin.

Dr. Philip E. Pier*

. . . Menasha, and Dr. Thomas J. Malueg, Appleton, recently joined the staff of the Riverside Clinic, Neenah–Menasha. Doctor Pier graduated from the University of Illinois Medical School and interned at Milwaukee County Hospital. He served with the United States Air Force and has been a resident in general and vascular surgery at Marquette School of Medicine for the past four years.

Doctor Malueg graduated from the University of Wisconsin Medical School and interned at St. Mary's Hospital, Los Angeles, Calif. He served his residency in psychiatry at the University of Wisconsin Hospitals, Madison, and was a staff psychiatrist at California Naval Hospital. He recently was Chief of the Service of Female Adult Psychiatry at Winnebago State Hospital, Winnebago.

Dr. Clifford Kampine*

. . . Marathon physician for the past 34 years, recently was honored at a testimonial dinner at the Rib River Ballroom, Wausau, for his services to the community.

Wisconsin General Practitioners to Meet

A three-hour program on "Family Practice Departments in Our Medical Schools" will be one of the hightlites of the 21st annual Scientific Assembly of the Wisconsin Academy of General Practice, October 8–9, at the Holiday Inn No. 2 in Madison.

The Family Practice session, on the morning of October 9, will feature Dr. Eugene Farley, who heads the Family Practice program at the Rochester School of Medicine, Rochester, N. Y. Dr. Farley's program is considered one of the most successful in the country.

Dr. Thomas Johnson, a staff member of the American Academy of General Practice, has been invited to speak on "What the AAGP Is Doing" in regards to family practice programs and residencies. Dr. Johnson, formerly in private practice in Tennessee, is now a full-time staff member of the AAGP, assigned to the Education Commission, with responsibility for assisting schools and hospitals in establishing family practice programs.

Dr. Norbert G. Bauch,* Milwaukee, chairman of the WAGP Committee on Professional and Public Policy, will open this phase of the program. Dr. Bauch has spent the last several months studying the family practice programs in several medical schools. The information he has gathered will be used in assisting the two medical schools in Wisconsin in formulating family practice programs.

Representatives from the University of Wisconsin Medical School and Marquette School of Medicine will round out the program on Family Practice.

The complete scientific program has been announced by Dr. Eugene Usow,* Milwaukee, chairman of the WAGP Committee on Scientific Assembly.

In addition to the session on family practice programs, Dr. Usow has announced sessions on pediatrics, surgery in Vietnam, neurology, hyperlipemias, and thyrocalcitonin.

A full afternoon on Wednesday, October 8, will be devoted to pediatrics.

Dr. June M. Dobbs of Children's Hospital in Milwaukee will open the program speaking on the complete pediatric physical examination.

Dr. Meyer S. Fox,* a leading authority on hearing problems in Wisconsin, will speak on pediatric ENT and hearing problems. Dr. Fox is from Milwaukee.

Following Dr. Fox, Dr. Brooks J. Poley of Minneapolis will speak on pediatric eye problems.

The fourth panelist, Dr. Harold Borenz of Madison, will discuss the

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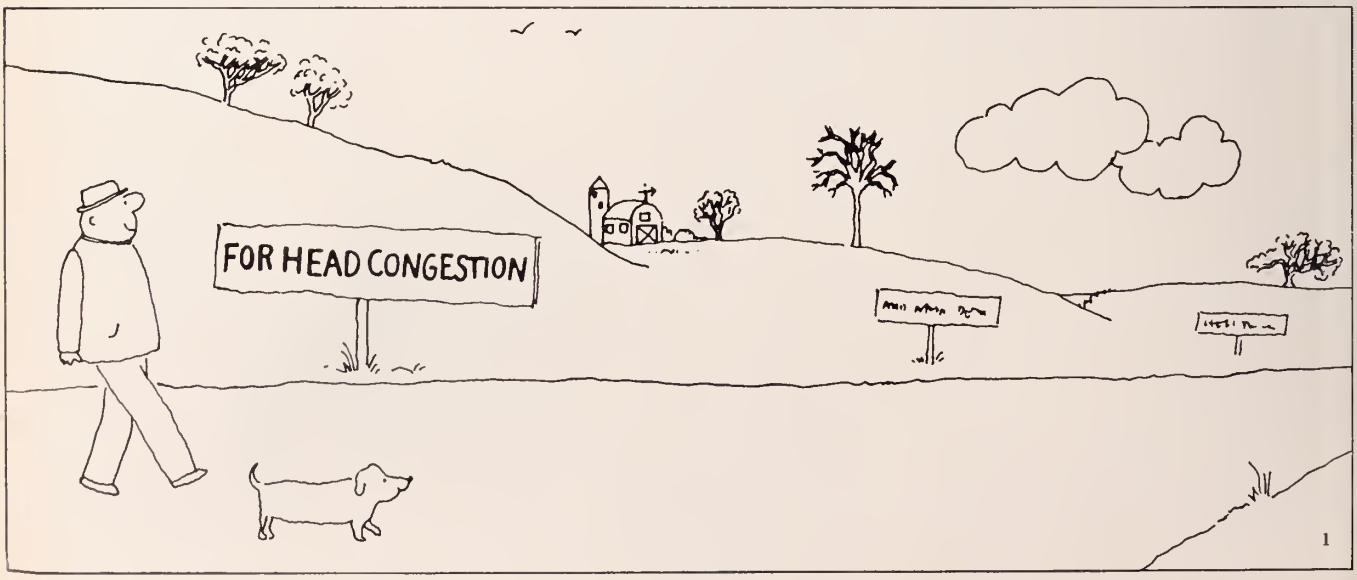


GENERAL PRACTITIONERS

continued

hyperkinetic child. The pediatric program will close with a question and answer panel discussion.

Surgery in Vietnam will be the interesting session that opens the program on Thursday afternoon. Dr. Sydney Wynn* of Milwaukee and Dr. Larry Carey of Pittsburgh will share the microphone on the two-hour program. Both have recently returned from duty in Vietnam.

Dr. Wynn is a Milwaukee plastic and reconstructive surgeon. Dr. Carey, formerly on the faculty of the department of surgery at Marquette, is now associate professor of surgery at Pittsburgh.

Dr. Gerald Salen of Rockefeller University in New York City will present a program on the newer methods of treatment of the different hyperlipemic disorders on Thursday afternoon.

Following Dr. Salen, Dr. Henry M. Suckle,* Madison, will present a paper on "Avoiding Unnecessary Delays in Neurosurgical Treatment."

The final speaker of the program is Dr. Will G. Ryan of the Section of Endocrinology and Metabolism, Presbyterian–St. Luke's Hospital, Chicago, Ill. Dr. Ryan will discuss thyrocalcitonin.—Reprinted from THE WISCONSIN FAMILY PHYSICIAN, Summer Issue 1969.

California and Minnesota Take One-third of Interns

The 94 University of Wisconsin Medical School graduates of 1969 have scattered to the following states for their internships:

Alabama	1
Arizona	5
California	19
Canada	1
Colorado	4
Florida	1
Hawaii	2
Illinois	2
Iowa	1
Kansas	1
Kentucky	1
Maryland	4
Massachusetts	1
Michigan	5
Minnesota	14
Missouri	1
New York	9
New Hampshire	1
Ohio	3
Pennsylvania	1
Texas	3
Utah	1
Washington	6
Wisconsin	7

Manawa Has New Doctor

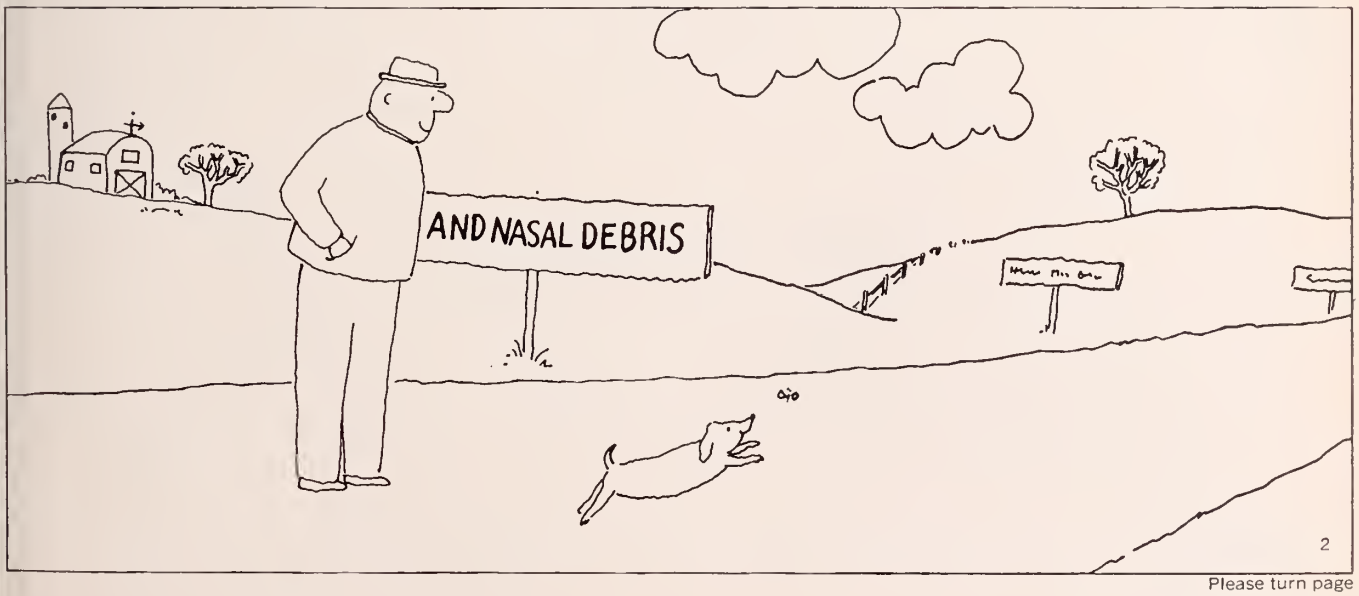
Dr. Cesar Garvida began practice in Manawa August 15 as a result of recruitment activities by Manawa Industries, Inc., a nonprofit corporation of Manawa citizens interested in promoting Manawa.

Dr. E. Paul Tischer

. . . Richland, a specialist in internal medicine and gastroenterology, recently became associated with the Richland Medical Center staff. Doctor Tischer graduated from the University of Indiana Medical School, did postgraduate work at the Mayo Foundation and Mayo Clinic, Rochester, Minn., and received his fellowship in internal medicine from the Mayo Foundation. He served as an instructor in the Indiana University Medical School and was chief of gastroenterology, chief of allergy, and assistant chief of medicine at the Regional Hospital at Chanute Field, Ill. Doctor Tischer has been a delegate to the American Society of Internal Medicine from Indiana and is a diplomate of the American Board of Internal Medicine.

Dr. S. Paul Kuwayama*

. . . recently became associated with the staff of Medical Associates, Menomonee Falls. He received his medical degree from Hokkaido University School of Medicine, Japan, and interned at the United States Naval Hospital, U. S. 7th Fleet Pacific, and St. Mary's Hospital in Milwaukee. He completed his fellowship in Pediatric Allergy at the University of Kansas School of Med-



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icine and Children's Mercy Hospital, Kansas. Doctor Kuwayama was a staff pediatrician at the Atomic Bomb Casualty Commission in Hiroshima, and in 1968 he completed a postdoctoral fellowship in immunology and a second-year fellowship in pediatric allergy at the University of Kansas School of Medicine. He is a diplomate of the American Board of Pediatrics and recently became appointed clinical instructor at Marquette School of Medicine.

Dr. Mayer Katz

. . . recently joined the staff of Beloit Clinic. He graduated from the University of Maryland Medical School and completed his internship at the University of California, San Francisco. He did residency work at Boston City Hospital. Doctor Katz was stationed in Vietnam for a year and spent another year of military duty at Ft. Ord, Calif. He is a diplomate of the American Board of Surgery.

Dr. Raymond Headlee*

. . . Elm Grove, chairman of the Department of Psychiatry, Marquette School of Medicine, and in private practice in Elm Grove, recently was appointed to the Board of Directors of the new Elmbrook Memorial Hospital, Brookfield.

Dental Society Has Meeting at Museum

The Executive Council of the Wisconsin State Dental Society held its mid-summer meeting at Old Fort Crawford's Museum of Medical Progress, August 1–2, in Prairie du Chien.

The invitation to use the Fortress Museum as a meeting place was sent by the State Medical Society of Wisconsin as a professional courtesy.

A source of interest to thousands of families annually, the Museum complex has special significance for the Dental Society. The Museum contains a full-fledged dentist's office from the turn of the century, complete with foot-pumped drills.

The Museum reflects progress in the whole field of health care from the early fur-trading days along the Northwest Frontier to the present.

Fort Crawford dates back to 1829 and the days of Indian scares. The Prairie du Chien site served under three flags: French, British and American. The Museum itself is a national registered landmark.

The Stovall Hall of Health, housed in an adjacent building, holds exhibits that cover a full range of current medical knowledge on today's health problems. It also contains the unique "Transparent Twins," full-sized plastic ladies who "talk."

The historical establishment is open daily to the public from 9:00 a.m. to 5:00 p.m., April 15 through October 31. It is owned and operated by the Charitable, Educational and Scientific Foundation of the State Medical Society.

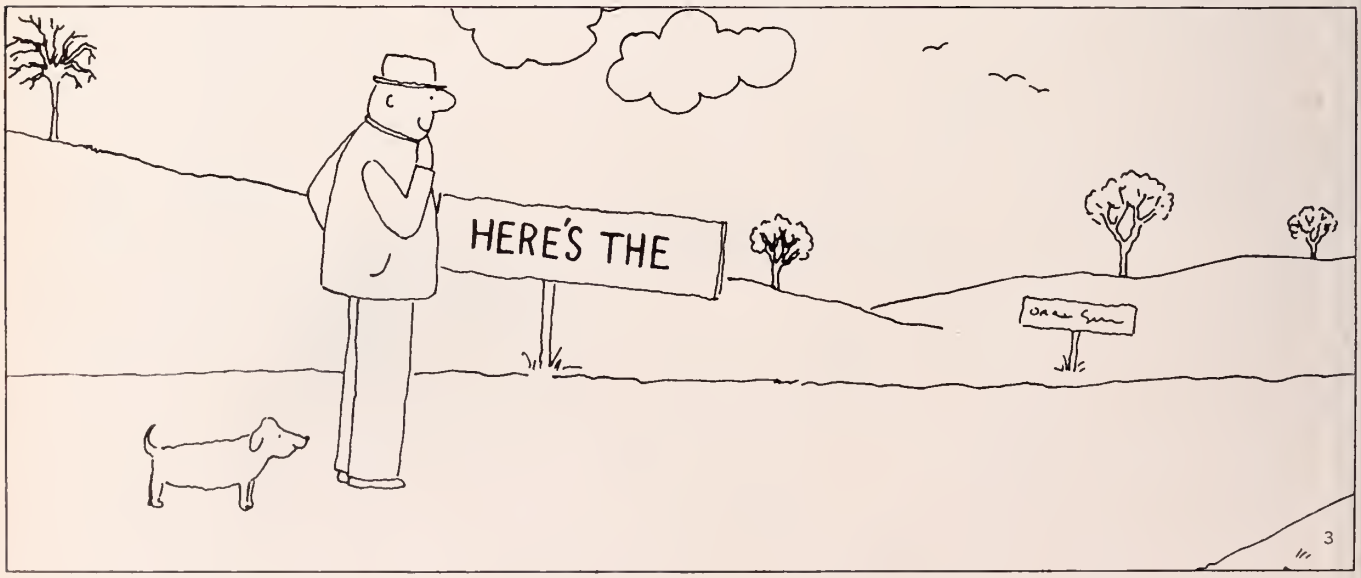
State Pathologists to Meet Nov. 22

The Annual Fall Meeting of the Wisconsin Society of Pathologists will be held Nov. 22 at St. Mary's Hospital in Madison. Topic for the meeting is "Forensic Pathology." Program details will appear in the October issue.

FILM AVAILABLE ON WISCONSIN PRECEPTOR PROGRAM

A color film of Dr. William S. Middleton discussing the history, development, and philosophy of the University of Wisconsin Medical School preceptor program has been completed by the Wisconsin Medical Alumni Association with support from the Alumni Annual Giving Fund. It will be used to help orient UW medical students, but also it will be available for general use and a tape of the sound track can be purchased if there is sufficient interest.

Further information may be obtained from the Wisconsin Medical Alumni Association, Inc., 333 North Randall Avenue, Madison, Wis. 53706.



Wisconsin Nurses Association to Meet

The Nurse and Innovation in Health Services is the theme for the annual convention of the Wisconsin Nurses Association, to be held October 8–11 at the Sheraton–Schroeder Hotel, Milwaukee. A highlight will be the observance of the organization's 60th year.

Speakers developing the "innovation" theme will be Howard J. Brown, MD, director of community medicine, Misericordia Hospital, The Bronx, New York, "Changes in Health Services: Their Implications for Nurses;" Mrs. Barbara A. Resnik, RN, University of Kansas Medical Center, Kansas City, "Primary Care: A New Role for Nursing in the Ambulatory Setting;" Mildred L. Mouw, RN, mental health nurse consultant, Department of Public Health and Welfare, County of San Mateo, San Mateo, California, "What Can I Contribute to the Community's Mental Health?".

The Wisconsin Nurses Association was organized June 25, 1909, at Children's Hospital, Milwaukee, and in commemoration a Diamond Jubilee Banquet will be held Wednesday, evening, Oct. 8, with all living WNA past presidents as honored guests.

Nursing clinics will be held Thursday afternoon and evening. The subjects include: "Health Promotion Through Nursing: Cessation of Smoking;" "Ritualism in the Practice of Nursing;" "Mother-Child Relationship: Separation;" "Personalized Nursing Care for Patient With Cardiovascular Surgery;" "Anxiety Levels in Pre- and Post-Surgical Patients;" "Teamwork to Meet the Continuing Needs of the Patient With a Hemipelvectomy," and "Tools for Learning in Nursing." This last clinic will be held at the new Nursing Resource Laboratory at the University of Wisconsin–Milwaukee, Greene Hall, 3347 North Downer Avenue, Milwaukee.

All registered professional nurses and nursing students in Wisconsin are invited to attend, regardless of whether they are members of the state association, according to Mrs. Alice A. Weldy, executive secretary.

Mental Health Clinic Opened, Rice Lake

The Lakeside Mental Health Clinic under the medical supervision of Dr. A. A. Lorenz* of Eau Claire has been established in Rice Lake following a declaration of need by the Barron–Washburn–Sawyer–Burnett County Medical Society.

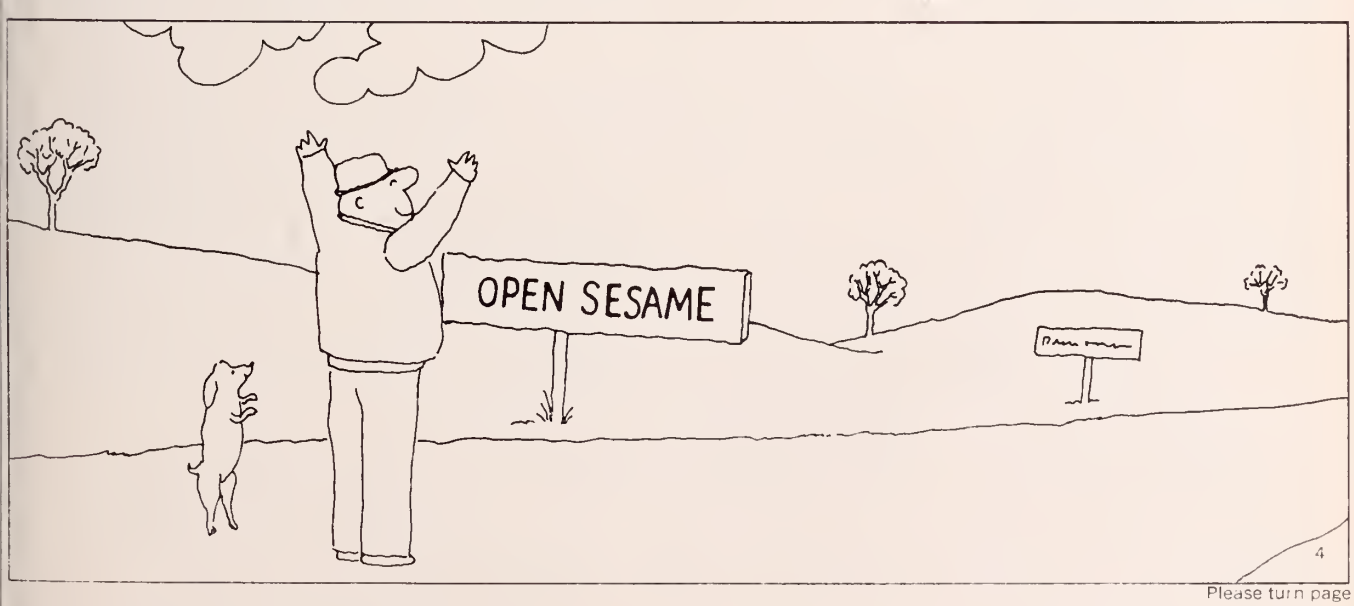
The new medical service is prepared to offer psychiatric services to residents of the four-county area mostly on a referral basis from family physicians.

Dr. Regalado Tendero

. . . recently joined the medical staff of St. Francis Hospital, La Crosse. Doctor Tendero completed his internship at Mercy Hospital, Cedar Rapids, Iowa, and did residency work in pathology in Peoria, Ill. He also completed residencies in anesthesiology, general surgery, obstetrics and gynecology in Pittsburgh, Pa. He served as a resident in anesthesiology in Chattanooga, Tenn., and was a medical officer and anesthesiologist at Princess Margaret Hospital, Nassau, Bahamas. Before coming to La Crosse, he completed a fellowship in anesthesia at Marquette School of Medicine and did general anesthesia at the Milwaukee County General Hospital.

Dr. Hania W. Ris*

. . . Madison, in May was elected to fellowship in the American Academy of Pediatrics and in July was elected to membership in the Society for Adolescent Medicine, a newly formed organization established to foster and stimulate the highest quality of medical care for adolescents and to increase the understanding of the adolescent period of growth and development. Doctor Ris is medical director of the Wisconsin School for Girls and is in private practice as well as



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being on the clinical faculty of the pediatrics department of the University of Wisconsin Medical School.

Dr. Thomas Kroner

. . . of the Milwaukee County Mental Health Center, North Division, has offered his services for one day a week as staff psychiatrist to the Washington County Guidance Center. Doctor Kroner served his psychiatric residency from 1966 to 1969 at the Milwaukee County Mental Health Center and was raised in Milwaukee, allowing him familiarity with the Washington county area.

Dr. C. A. Olson*

. . . Baldwin, in August was appointed to the Council on Hospital Construction, an advisory board to the Division of Health, State Department of Health and Social Services. Doctor Olson is a practicing physician associated with the Baldwin Clinic. The Council on Hospital Construction is a statutory advisory committee to the Division of Health on the state plan for development of hospitals and related facilities, and for the distribution of federal funds allocated to Wisconsin for construction of medical facilities. Announcement was made by the State Council on Health. It's a three-year term.

Mexican Retreat/Seminar—UW Alumni

The Fourth Annual Alumni/Faculty Retreat of the Wisconsin Medical Alumni Association will be held in Puerto Vallarta, Mexico, Feb. 14–21, 1970.

Eighteen hours of intensive professional instruction will be handled by the following faculty members: Dr. Raymond Chun,* neurology and pediatrics; Dr. Benjamin Glover, Jr.,* psychiatry; Dr. Donald Korst,* medicine; Dr. Sanford Mackman,* surgery; Dr. Arthur Siebens,* rehabilitation medicine and pediatrics; and Dr. Richard H. Wasserburger,* medicine. They will discuss such topics as anticonvulsants, drug interactions, management of chest trauma, problems attendant upon brain damage, identification and therapy of coronary artery disease, and acute and chronic paraplegia.

The lectures will be mandatory for those on the tour but there will be many sun-filled hours of relaxation for both the physician and his wife.

On the return flight there will be a one-day and night stopover in Mexico City.

Included in the tour fee ($999 per couple and $688 for an individual) will be round trip air transportation from Chicago to Puerto Vallarta on Mexico's West Coast, then return by way of Mexico City to Chicago.

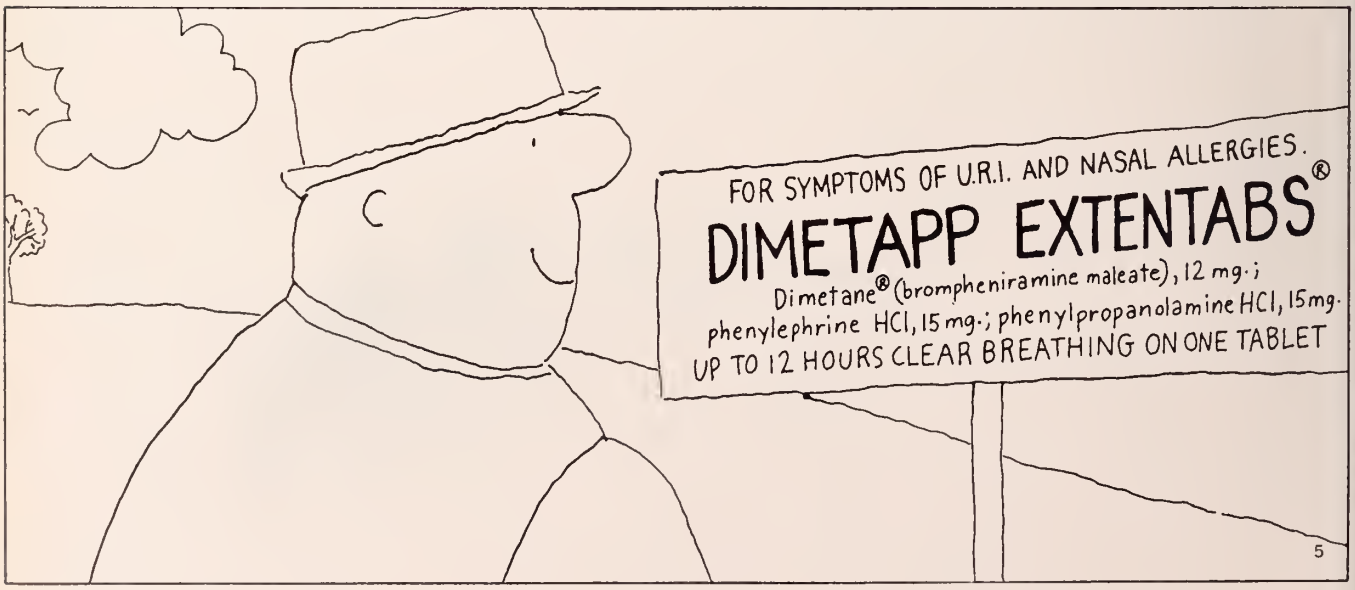
Limit: 60 persons. Register with Wisconsin Medical Alumni Association, % Mr. Ralph Hawley, 333 North Randall Avenue, Madison, Wis. 53706.

Society Honors 4-H Clubs Health–Safety Program

Nine 4-H clubs in Wisconsin have received a Health Achievement Award from the State Medical Society of Wisconsin in recognition of outstanding accomplishments in the 4-H club health and safety program during 1968.

The award, given annually for several years, includes a certificate signed by the presidents of the county and state medical societies, the book, "Today's Health Guide," a publication of the American Medical Association, and a free pass to the Museum of Medical Progress in Prairie du Chien.

Clubs receiving the award are: Shooting Stars, New Franken; Up & Over, Blanchardville; Phlox Flames, Antigo; Helpful Workers, Ellsworth; Horse Creek Hustlers, Richland Center; 4 K's, Hayward; Shaw-Oco, Oconto Falls; and Casey Lake 4-H, Waupaca.



Medical School Deans Appointed to WRMP

The Wisconsin Regional Medical Program, Inc. (WRMP) recently announced the appointment of five new members to its board of directors.

They are: Dr. Peter L. Eichman,* dean of the University of Wisconsin Medical School, and Wallace L. Lemon, director of planning and facilities, University of Wisconsin, both of Madison; Eugene W. Arnett, administrator, Memorial Hospital of Taylor County, Inc., Medford; Arthur C. Moeller, vice-president for academic affairs, Marquette University, Milwaukee; and Dr. Gerald A. Kerrigan,* dean of Marquette School of Medicine, Inc., Milwaukee.

Reelected were: Edmund Fitzgerald, former president of the Northwestern Mutual Life Insurance Co., Milwaukee, vice-president; Dr. Frank E. Drew,* past president, State Medical Society of Wisconsin, Milwaukee; Orval H. Guenther, former director, Milwaukee County Institutions and Departments; and T. A. Duckworth, senior vice-president and secretary, Employers Insurance of Wausau, Wausau, president.

The WRMP is a cooperative program through which medical schools, hospitals, clinics, physicians, nurses, voluntary health agencies, and others throughout Wisconsin can receive and give each other faster and more thorough assistance in combating heart disease, stroke, or cancer.

As members of the board of directors, it will be their responsibility to see that the objective is carried out for the benefit of people living in the Wisconsin region. □

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF AUGUST 1969

- 2 SMS Council Committee on Scientific Medicine
- 2 SMS Council
- 3 SMS Council
- 5 Pediatric Cardiology Planning Committee, Wisconsin Regional Medical Program
- 8 SMS Commission on Scientific Medicine
- 11 Dane County Medical Society Insurance Advisory Committee
- 14 SMS Committee on Medicine and Religion
- 21 Executive Committees of SMS Commission on Medical Care Plans and WPS Charge Card Corporation
- 21 Wisconsin Regional Medical Program Staff

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Drs. David S. Hathaway

. . . and Gilbert R. Wessel, recently joined the staff of Riverside Clinic, Menasha. Doctor Hathaway was a Fulbright scholar at the University of Edinburgh, Scotland, before graduating from Baylor University College of Medicine in 1963. He served his internship at St. Mary's Hospital, Duluth, Minn., and his residency at the Mayo Clinic, Rochester. Doctor Hathaway was chief of the dialysis–transplantation program section in the kidney disease program of the United States Public Health Service before joining Riverside Clinic. Doctor Wessel graduated from the University of Iowa Medical School in 1963 and served his internship at Hurley Hospital, Flint, Mich. His residency in obstetrics and gynecology was taken at the University of Iowa hospitals. He recently was discharged from the United States Air Force.

Dr. Frank P. Goldstein*

. . . Milwaukee and Racine, assistant professor, Marquette School of Medicine, recently was certified by the American Board of Neurological Surgery. He also was accepted as a member of the Neuropsychiatric Society and the Neuroelectric Society. □

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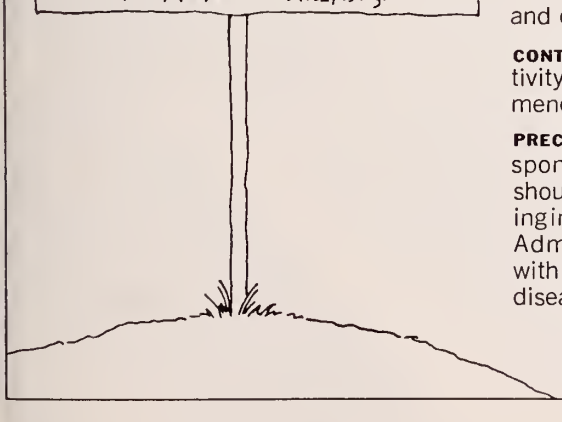

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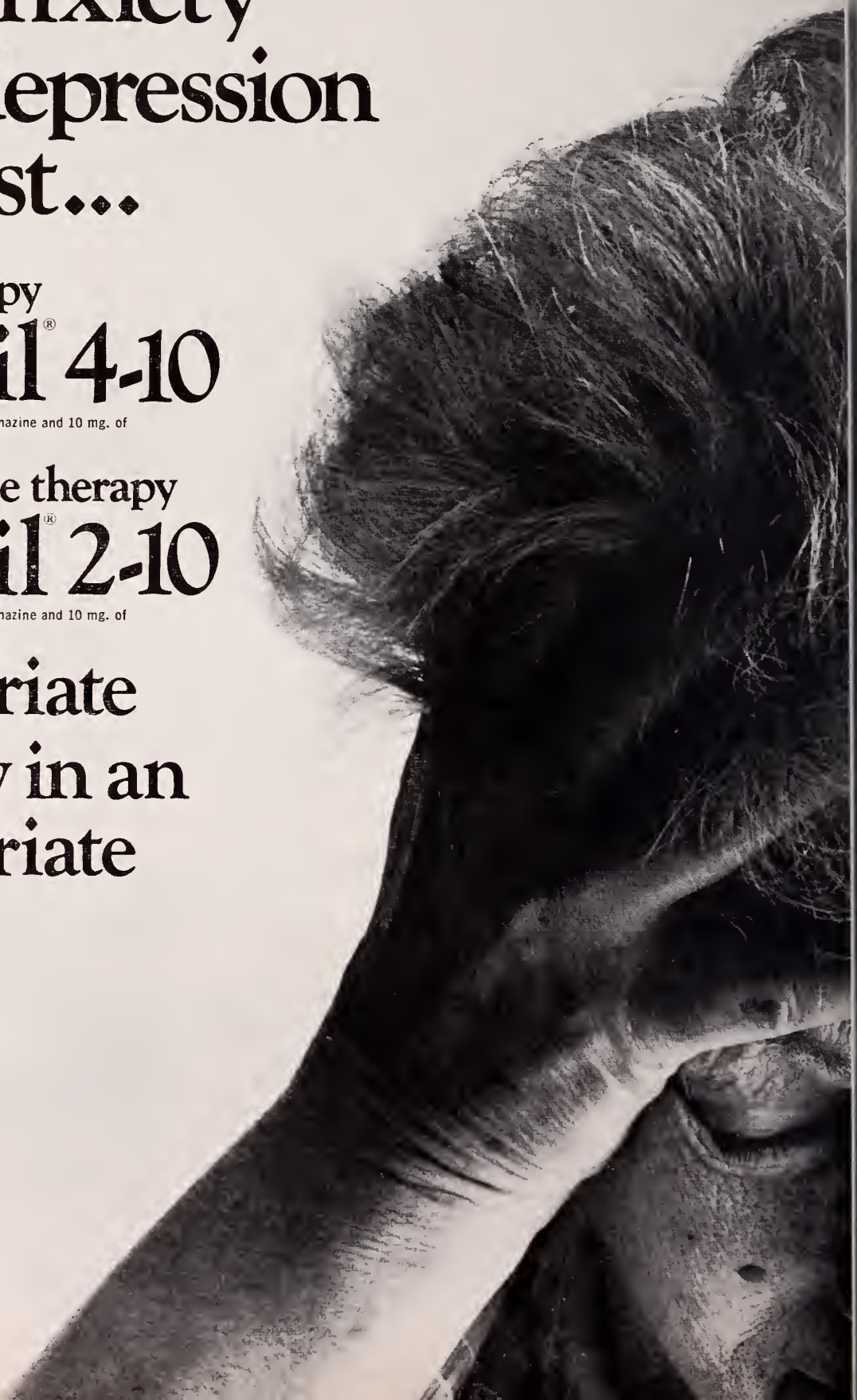

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Altman, Ruben, 630 South Central Ave., Marshfield 54449
Atamdede, Aysel, 6501 South 116th St., Franklin 53132
Bersalona, Fernando B., 630 South Central Ave., Marshfield 54449
Combs, James A., 1300 University Ave., Madison 53706
Crowell, Edward B., Jr., 1300 University Ave., Madison 53706
Dodds, Wylie J., 21540 Sierra Dr., Waukesha 53186
Donahue, Parnell, 6080 South 108th St., Milwaukee 53228
Kelley, Thomas J., Box H, Winnebago 54985
Kriss, Frederick C., 20 South Park St., Madison 53715
Liebermann, Michael C., 945 North 12th St., Milwaukee 53226
Limjoco, Uriel Romey, 2500 Overlook Terr., Madison 53705
Malueg, Thomas J., 1101 East Taft Ave., Appleton 54911
Rodriguez, Justo, 630 South Central Ave., Marshfield 54449
Shambaugh, George E., III, 1215 Linden Dr., Madison 53706
Ulmer, Richard H., 630 South Central Ave., Marshfield 54449

CHANGES OF ADDRESS

Adams, Harold G., Brandon, to P. O. Box 247, Markesan 53946
Blahnik, Clarence L., Mehlville, Mo., to 25 New England Ct., Gretna, La. 70053
Botka-Wunder, Gabriella M., Milwaukee, to Southern Wisconsin Colony, Union Grove 53182
Buttles, Anson J., 425 East Wisconsin Ave., Milwaukee 53202
Chopyak, John A., FPO, San Francisco, Calif., to 3333 South 27th St., Milwaukee 53215
Cook, Colin B., Milwaukee, to Cornell Medical Center, 21 Bloomingdale Rd., White Plains, N. Y. 10605
Corcoran, W. A., Jr., Wauwatosa, to 430 West Jefferson St., Port Washington 53074
Dettmann, J. E., 1751 Deckner Ave., Green Bay 54302
Dortzbach, Richard K., 1714 Wicklow Way, Madison 53711
Ellison, Edwin H., 7540 North Beach Dr., Milwaukee 53217
Fitzgerald, Gerald P., Janesville, to 124 South Third St., Delavan 53115
Gorder, Arne C., 727 East Juniper Lane, Milwaukee 53217
Guthrie, J. M., Jr., 1751 Deckner Ave., Green Bay 54302
Huizenga, B. A., Milwaukee, to 14895 San Raphael, Brookfield 53005
Landmann, G. A., 301 Superior Ave., Tomah 54660
Leenhouts, K. C., Menomonee Falls, to Route 2, Box 383A, Waukesha 53186
Mathews, Richard J., 2266 North Prospect Ave., Milwaukee 53202
Martinez, Marcel E., 523 Main St., Racine 53403
Martins, Ronald R., Milwaukee, to 5341 Orchard Lane, Greendale 53129
Miller, Wallace C., 523 Main St., Racine 53403
Pier, Philip E., Milwaukee, to 59 Racine St., Menasha 54952
Pophal, Charles J., Long Beach, Calif., to 356 Dumbarton Rd., Richmond Heights, Ohio 44143
Sargeant, George M., Baldwin, to 3807 West Cheyenne, Milwaukee 53209
Schmidt, Clayton H., Wurtsmith AFB, Mich., to CMR-#5547, 6217 USAF Hospital, APO, San Francisco, Calif. 96319
Shaiken, Joseph, 1610 North Prospect, Milwaukee 53202
Smith, Harlan M., 2725 Marshall Court, Madison 53705
Vergamini, Jerome C., Madison, to Medical Group, Malmstrom AFB, Great Falls, Mont. 59401
White, Ellison F., Union Grove, to 2600 Pavilion Rd., Racine 53405

DEATHS

Bauer, Kilian T., Washington County, July 11, 1969 □

OBITUARIES

Dr. Ralph P. Sproule, 75, Milwaukee, former president of the State Medical Society of Wisconsin, died June 27, 1969, in Milwaukee.

Born on May 29, 1894, in Milwaukee, Doctor Sproule received his medical degree from Northwestern University in 1919 and interned at Milwaukee Hospital. His residency was taken at the J. C. Beck Clinic, Chicago, Ill., from 1920–22.

Doctor Sproule was a specialist in ophthalmology, otology, laryngology and rhinology. He served as president of the State Medical Society of Wisconsin in 1941 and was a former president of The Medical Society of Milwaukee County and the Milwaukee Academy of Medicine. He was a fellow in the American Laryngological, Rhinological, and Otological Society and International College of Surgeons. He was a life member of the Milwaukee Academy of Medicine, and was honored into the "Fifty-Year Club" at the annual meeting of the State Medical Society of Wisconsin in May 1969.

Doctor Sproule was a member of the Council of the State Medical Society for five years and was a member of the Chicago Otolaryngological, Rhinological and Otological Society, American Academy of Ophthalmology and Otolaryngology, Wisconsin Otolaryngological Society, Pan American Association of Ophthalmology, and the American Medical Association. He was on the staffs of the Milwaukee, Columbia, Milwaukee Children's hospitals and was an oculist for several railroads.

Surviving are his widow, Ilse; and a daughter, Mrs. Winston (Phoebe) Markey, and two sons, John H., and Dr. Ralph T., both of Milwaukee.

Dr. Kilian T. Bauer, 88, former West Bend physician for 50 years, died July 11, 1969, in Elm Grove.

Doctor Bauer was born in Germany July 7, 1881, and graduated from the Wisconsin School of Physicians and Surgeons (now Marquette School of Medicine). In 1917, he became associated with the late Dr. A. H. Heidner and retired in 1957.

He was a member of the Ozaukee County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are a daughter, Mrs. Harold (Helen) Wright, of Festus, Mo., and a son, Dr. Carroll A. Bauer, Elm Grove. □

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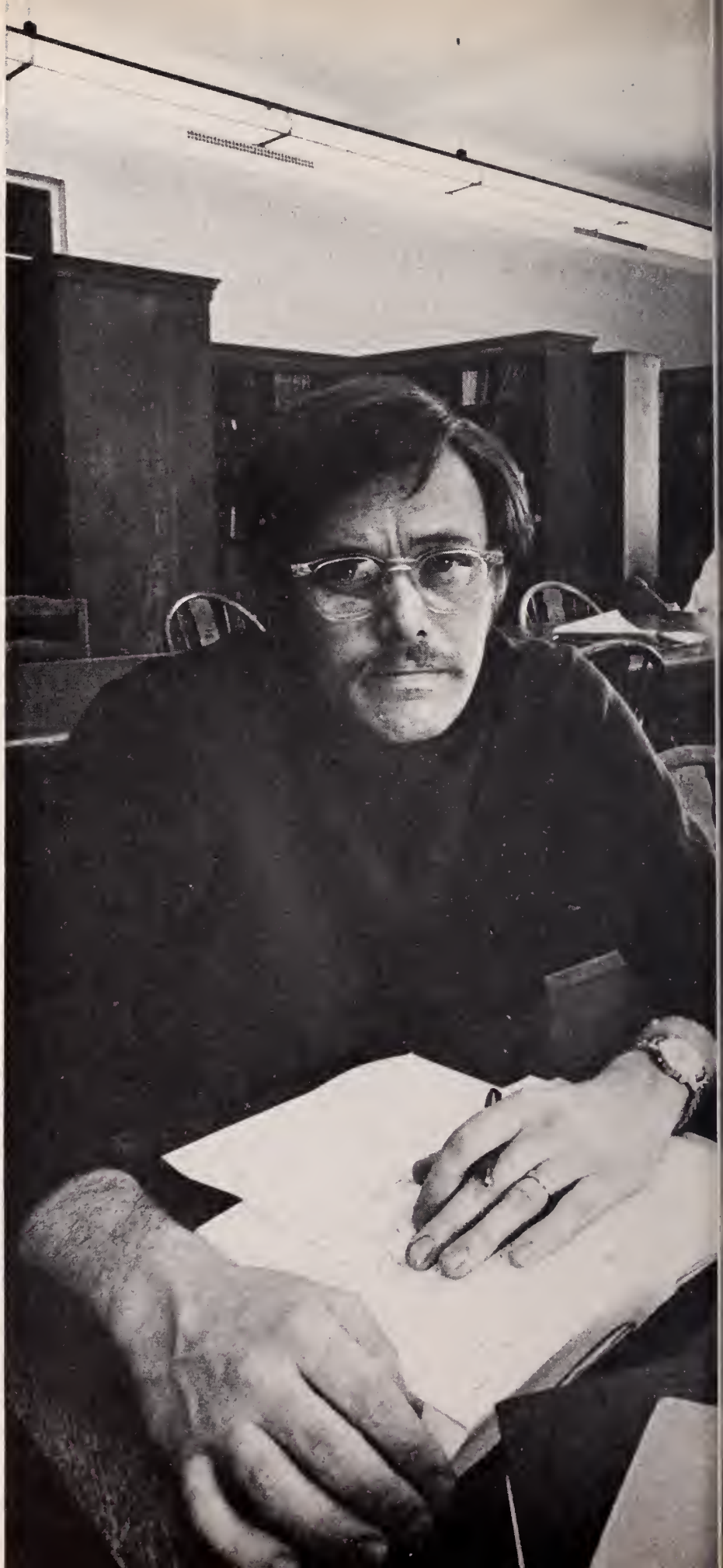

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COUNTY MEDICAL SOCIETIES

Presidents and secretaries of the 54 component county medical societies are listed periodically.

COUNTY MEDICAL SOCIETIES

Presidents and Secretaries

County Medical Society	*President*	*Secretary*
Ashland–Bayfield–Iron	A. A. Koeller 206 6th Ave. W. Ashland 54806	John Kreher 522 2nd St. W. Ashland 54806
Barron–Washburn–Sawyer–Burnett	Frederick Bannister 220 Douglas Chetek 54728	D. G. MacMillan 1220 E. Woodland Barron 54812
Brown	Robert T. Schmidt P.O. Box 354 Green Bay 54305	John Wallerius 3755 S. Webster Ave. Green Bay 54301
Calumet	John A. Knauf Stockbridge 53088	J. C. Pinney Hilbert 54129
Chippewa	Diane A. Dahl Chippewa Falls 54729	Clarence E. Zenner Cadott 54727
Clark	Bahri Gungor Neillsville 54456	Ana C. Capati 305 Sunset Pl. Neillsville 54456
Columbia–Marquette–Adams	Stewart F. Taylor 116 E. Pleasant St. Portage 53901	Weston W. Jones 130½ W. Cook St. Portage 53901
Crawford	James R. Wong 229 S. Michigan St. Prairie du Chien 53821	James R. Wong 229 S. Michigan St. Prairie du Chien 53821
Dane	Thomas V. Geppert 1313 Fish Hatchery Rd. Madison 53715	Walter R. Sundstrom 1912 Atwood Ave. Madison 53704
Dodge	Roger I. Bender 205 S. University Beaver Dam 53916	F. G. Haessly P.O. Box 512 Beaver Dam 53916
Door–Kewaunee	Reynold M. Nesemann 213 Ellis Street Kewaunee 54216	Luis L. Galang Algoma 54201
Douglas	R. R. Mataczynski 1514 Ogden Ave. Superior 54880	Robert Mann 515—3rd Ave. E. Superior 54880
Eau Claire–Dunn–Pepin	Harry Gonlag 314 E. Grand Ave. Eau Claire 54701	William J. Beckfield 310 Chestnut St. Eau Claire 54701
Fond du Lac	J. G. Parrish, Jr. 1921 Mulen Drive Fond du Lac 54935 *Treasurer:* Arnold Bisseger 80 Sheboygan St. Fond du Lac 54935	David Lawrence 92 E. Division St. Fond du Lac 54935
Forest	E. F. Castaldo Laona 54541	D. V. Moffet Crandon 54520
Grant	Stanley J. Nuland 27 N. Elm St. Platteville 53818	H. W. Carey 257 Madison St. Lancaster 53813
Green	John M. Irvin 2101 Sixth St. Monroe 53566	B. M. Rush 1515 Tenth St. Monroe 53566
Green Lake–Waushara	R. A. Kjentvet Wild Rose 54984	Roy Hong Wild Rose 54984
Iowa	N. G. Rasmussen 109 W. Fountain Dodgeville 53533	H. P. Breier Montfort 53569
Jefferson	Richard H. Siedenburg 106 E. John St. Jefferson 53549	George Nemec, Jr. Cambridge 53523
Juneau	Jack Strong Mauston 53948	Clayton Weston New Lisbon 53950
Kenosha	Gene F. Armstrong 6530 Sheridan Rd. Kenosha 53140	C. E. Peterson 1400—75th St. Kenosha 53140 *Exec. Secy.* Mr. Mark J. Gorman 3916—67th St. Kenosha 53140
La Crosse	S. B. Gundersen, Jr. 1836 South Ave. La Crosse 54601	James C. Tankersley 1707 Main Street La Crosse 54601
Lafayette	Richard E. Hunter Argyle 53504	L. L. Olson 504 Wells St. Darlington 53530
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Lincoln	R. J. Henderson 327 W. Wisconsin Ave. Tomahawk 54487	James S. Janowiak 716 E. 2nd St. Merrill 54452
Manitowoc	H. E. Schaefer 1036 S. 8th St. Manitowoc 54220	H. P. Miller, Jr. 2300 Western Ave. Manitowoc 54220
Marathon	Arthur W. Hoessel 400 Strollers Lane Wausau 54401	William D. Backer 630 First St. Wausau 54401
Marinette–Florence	Robert J. DeWitt 516 Houston St. Marinette 54143	K. G. Pinegar 516 Houston St. Marinette 54143
Milwaukee	Howard L. Correll 6745 W. Wells St. Milwaukee 53213 *Treasurer:* Benjamin G. Narodick 2040 W. Wisconsin Ave. Milwaukee 53233	L. W. Worman 8700 W. Wisconsin Ave. Milwaukee 53226 *Exec. Secy.:* Mr. J. O. Kelley 756 N. Milwaukee Milwaukee 53202
Monroe	Dewitt Beebe Sparta 54656	E. O. Lukasek 110 E. Franklin Sparta 54656
Oconto	Kenneth Strebe 134 N. Main St. Oconto Falls 54154	John S. Honish 1113 N. Main St. Oconto 54153
Oneida–Vilas	John F. Brown 1020 Kabel Ave. Rhinelander 54501	Marvin Wright 1020 Kabel Ave. Rhinelander 54501
Outagamie	Frank Wright, Jr. 412 E. Longview Ave. Appleton 54911	William H. Hale 420 E. Longview Dr. Appleton 54911
Ozaukee	John E. Kippenhan 204 N. Washington Ave. Cedarburg 53012	Herbert F. Laufenburg 204 N. Washington Ave. Cedarburg 53012
Pierce–St. Croix	L. W. Weisbrod New Richmond 54017	C. A. Olson Baldwin 54002
Polk	Evan H. Peterson St. Croix Falls 54024	Arne T. Lagus St. Croix Falls 54024
Portage	F. W. Reichardt 2501 Main St. Stevens Point 54481	James R. Sevenich 554 College Ave. Stevens Point 54481
Price–Taylor	*Acting President:* Walter F. Niebauer Phillips 54555	Walther W. Meyer 410 S. Second Medford 54451

continued next page

County Medical Society	President	Secretary
Racine	Elizabeth A. Steffen 734 Lake Ave. Racine 53403 *Treasurer:* Marvin W. Nelson 837 Main Street Racine 53403	Wm. C. Harris 2405 Northwestern Ave. Racine 53404 *Exec. Secy.:* Mr. James Wilbershide P.O. Box 542 Racine 53403
Richland	Donald J. Taft 1313 W. Seminary Richland Center 53581	L. M. Pippin 1313 W. Seminary Richland Center 53581
Rock	David A. Cohen 1011 N. Main St. Edgerton 53534	R. S. Overton 58 S. Main St. Janesville 53545
Rusk	Ralph P. Bennett Ladysmith 54848	Joseph E. Murphy 403 E. Miner Ave. Ladysmith 54848
Sauk	Eugene L. Weston 703—14th St. Baraboo 53913	John T. Siebert 703—14th St. Baraboo 53913
Shawano	Donald A. Jeffries Shawano 54166	A. J. Sebesta P.O. Box 311 Shawano 54166
Sheboygan	Edward E. Houfek 417 Security National Bank Bldg. Sheboygan 53081	Robert A. Keller 1011 N. Eighth St. Sheboygan 53081
Trempealeau–Jackson–Buffalo	David B. Johnson 146 S. Eau Claire St. Mondovi 54755	Eugene Krohn 221 Main St. Black River Falls 54615
Vernon	P. T. Bland Westby 54667	DeVerne W. Vig 125 W. Jefferson Viroqua 54665
Walworth	Rocco S. Galgano 610 Walworth Ave. Delavan 53115	Joseph B. Schrock, Jr. 100 S. Washington St. Elkhorn 53121
Washington	W. A. Nielsen P.O. Box 379 West Bend 53095	R. F. Sorensen P.O. Box 408 West Bend 53095
Waukesha	J. J. Foley N82 W15401 Appleton Ave. Menomonee Falls 53051 *Treasurer:* W. J. Clothier, Jr. 1025 E. Broadway Waukesha 53186	M. Z. Fruchtman 1215 Downing Dr. Waukesha 53186 *Exec. Secy.:* Mr. Gale P. Brennan 186–60 Bonnie Lane Brookfield 53055
Waupaca	Wm. G. Arnold 46 N. Main St. Clintonville 54929	Joseph W. Weber 322 N. Water St. New London 54961
Winnebago	Donald J. Ryan 117 N. Commercial St. Neenah 54956	G. W. Arndt 706 E. Forest Ave. Neenah 54956
Wood	John J. Suits 650 S. Central Ave. Marshfield 54449	J. J. Mulvaney 630 S. Central Ave. Marshfield 54449

Five-Year Program Shows TB Decline

In 1963 the State Division of Health began a program to accelerate the eradication of tuberculosis in Wisconsin. In cooperation with the Wisconsin Anti-Tuberculosis Association and local health organizations, the first part of the program was aimed at early detection of new cases through skin tests and chest x-rays, followed by examinations of family members and fellow workers of all new cases found. At the heart of the program was the provision to supply —without charge—preventive medication to control active cases and to prevent inactive cases of tuberculosis from turning into active.

An analysis of the first five years of this tuberculosis eradication program has been completed. It shows that the incidence of new cases has declined nearly 40 percent in this period. In 1963, at the start of the program, 670 new cases of TB were reported. In 1968 the incidence dropped to 411 new cases.

The five-year report also revealed these facts:

. . . The decrease in new cases of TB was greatest in the rural areas of the state with nearly a 50 percent decline and least in the urban areas with a 36 percent decline.

. . . The age group 24 years and under showed a decline of over 50 percent; the age group 25 through 65 a decline of about 40 percent; and the age group over 65 a decline of near 28 percent. The less favorable results in the older age groups were likely caused by the breakdown of previously undetected infections.

. . . Wisconsin's Indian population had a decline in new cases of 60 percent, the white population a decline of 39 percent, and the Negro population a decline of 22 percent. The less favorable results in the urban areas and among the Negro population resulted from the same cause, that is the increasing population and the close proximity of living in the cities.

. . . The 1968 rate of new TB cases was 10.1 per 100,000 population as compared with the 1963 rate of 16.6 new cases per 100,000 population.

. . . Of the new cases reported in 1968, two-thirds were male and one-third female. This is the same ratio that has prevailed for many years.

The TB eradication program will continue with the goal of reducing the incidence of new cases by 10 percent each year. Total eradication in the near future may not be possible—one reason being the migration into our state of infected people—but we can reduce the incidence to a medical rarity. And even those who are afflicted, if they can be reached for preventive medication, can avoid illness and live near normal lives without fear of infecting others. □

FILM: FAMILY PLANNING

Contraceptive methods are reviewed for hospitalized postpartum women in a film now available through the Planned Parenthood Federation, Inc. The film, titled "Happy Family Planning," was produced under a financial grant from Wyeth Laboratories.

"Happy Family Planning" is an entertaining 8-minute animated color film with music, available in either 16-mm or 8-mm. The film, which presents its story in graphic devices and requires no dialogue, features various contraceptive devices which are identified in five languages: English, French, Spanish, Arabic and Chinese.

The film is designed for showing to lay groups, especially hospitalized women in the immediate postpartum period. It also can serve as a valuable educational aid in clinics, physicians' offices and at health meetings. The film is very useful where there is a language barrier, at all educational levels.

Prints of "Happy Family Planning" can be purchased at cost through Planned Parenthood Federation, 515 Madison Avenue, New York, New York 10022. □

MEDICAL MEETINGS
POSTGRADUATE COURSES

1969 WISCONSIN

Oct. 25: One-day Pediatric Symposium, Marshfield Clinic, Marshfield.

Nov. 6: Symposium by the State Medical Society of Wisconsin's Division on Nervous and Mental Diseases, Society Headquarters, Madison.

Nov. 14: Eighth Annual Medical–Legal Industrial Symposium—"Prevention of Industrial Disease and Injury," Mount Sinai Hospital, Milwaukee, at Hotel Pfister.

Nov. 19–21: Conference on Safety to Life and Property from Fire, National Fire Protection Association–International, Sheraton–Schroeder Hotel, Milwaukee.

Nov. 22: Fall meeting, Wisconsin Society of Pathologists, St. Mary's Hospital, Madison.

1969 NEIGHBORING STATES

Oct. 29–30: American Association for the Study of Liver Disease, Chicago, Ill.

Oct. 29–Nov. 2: American College of Chest Physicians, Chicago, Ill.

Nov.: American Society of Therapeutic Radiologists, Chicago, Ill.

Nov. 2–5: International Symposium on Atherosclerosis, Chicago, Ill.

Nov. 3–5: Clinical Reviews (to be repeated on Nov. 10–12), Mayo Clinic and Mayo Foundation, Rochester, Minn.

Nov. 3–7: Nuclear Medicine—Diagnosis and Treatment of Disease with Radionuclides Given Internally, American College of Physicians, University of Michigan Medical Center, Ann Arbor.

Nov. 3–14: Postgraduate course in Laryngology and Bronchoesophagology, Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago.

Nov. 8–9: North Central Medical Conference, St. Paul Hilton, St. Paul Minn.

Nov. 8–9: Conference on Radiology, University of Iowa Health Center, Iowa City.

Nov. 10–12: Clinical Reviews (repeat of Nov. 3–5), Mayo Clinic and Mayo Foundation, Rochester, Minn.

Nov. 11–15: American College of Preventive Medicine, Detroit, Mich.

Nov. 12: Frontiers of Medicine (fifth series)—Depression, University of Chicago, Chicago.

Nov. 21–22: Workshop on the Delivery of Medical Care in the 1970s, Institute of Medicine of Chicago, Ambassador Hotel, Chicago.

Nov. 28–29: Head and Neck Radiology Conference, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

Nov. 30–Dec. 5: Radiological Society of North America, Chicago, Ill.

Dec. 4–5: Conference on Obstetrics and Gynecology, University of Iowa Health Center, Iowa City.

Dec. 5–6: Cardiac and Respiratory Disease Conference, University of Iowa Health Center, Iowa City.

Dec. 10: Frontiers of Medicine (fifth series)—Trauma, University of Chicago, Chicago.

1969 OTHERS

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 12–15: Postgraduate conference, Mound Park Hospital Foundation and University of Florida, Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Nov. 17–21: Course in Neuroradiology with Clinical and Pathological Correlation, New York University Post-Graduate Medical School, New York.

Nov. 19–21: Emergency Service Procedures, University of Colorado School of Medicine, Denver.

Nov. 20: Annual Membership Meeting, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Dec. 6–11: Annual meeting, American Academy of Dermatology, Bal Harbour, Fla.

Dec. 8–11: Sixth Annual New Orleans Course on Pulmonary Function in Health and Disease, American Thoracic Society with others, Louisiana State University School of Medicine Auditorium, New Orleans.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium). Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psychosomatic Seminars), to South Pacific.

1969 AMA

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

Mar. 11: Conference on the Provision of Occupational Health Services to the Small Industrial Plant, Racine Motor Lodge, Racine (sponsored by the Committee on Occupational Health of the State Medical Society of Wisconsin).

Mar. 18: Symposium on Farm Accidents, Valhalla Hall, Wisconsin State University at La Crosse (sponsored by Committee on Occupational Health of the State Medical Society of Wisconsin).

May 11–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 NEIGHBORING STATES

Jan. 14: Frontiers of Medicine (fifth series)—Recent Progress in Human Genetics, University of Chicago, Chicago.

Feb. 11: Frontiers of Medicine (fifth series)—Abnormal Uterine Bleeding and Pain, University of Chicago, Chicago.

Feb. 16–18: Sectional Meeting, American College of Surgeons, St. Paul Hilton, St. Paul, Minn.

Mar. 1–4: Midwest Clinical Conference of the Chicago Medical Society, The Sherman House, Chicago.

Mar. 11: Frontiers of Medicine (fifth series)—Gout and Purine Metabolism, University of Chicago, Chicago.

Mar. 16–20: Clinical Problems in Internal Medicine, American College of Physicians, Cleveland, Ohio.

Mar. 23–26: Neurology and the Internist, American College of Physicians, Rochester, Minn.

Mar. 30–Apr. 3: Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, American College of Physicians, Ann Arbor, Mich.

Apr. 8: Frontiers of Medicine (fifth series)—Therapy of Leukemia and Lymphoma, University of Chicago, Chicago.

May 13: Frontiers of Medicine (fifth series)—Neurological Aspects of Systemic Disease, University of Chicago, Chicago.

June 8–12: Internal Medicine, 1970—Old Principles, New Practice, American College of Physicians, Iowa City, Iowa.

June 15–17: Blood Transfusion Therapy and Related Immunology, American College of Physicians, East Lansing, Mich.

Oct. 5–9: 53rd Annual Meeting, American Dietetic Association, Detroit, Mich.

1970 OTHERS

Jan. 9: Sectional Meeting, American College of Surgeons, Americana Hotel, San Juan, Puerto Rico.

Jan. 16–17: Sectional Meeting, American College of Surgeons, Mancuto–Sheraton Hotel, Caracas, Venezuela.

Jan. 18–24: Sixteenth Annual General Practice Review, University of Colorado School of Medicine, Denver.

Jan. 21–23: Sectional Meeting, American College of Surgeons, El Panama Hotel, Panama City, Panama.

Feb. 2–4: Sectional Meeting, American College of Surgeons, Portland Hotel, Portland, Ore.

Feb. 2–6: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Feb. 14–21: Fourth Annual Alumni/Faculty Retreat, Wisconsin Medical Alumni Association, Puerto Vallarte, Mexico.

Mar. 16–18: Sectional Meeting, American College of Surgeons, Sheraton Park Hotel, Washington, D.C. (Combined annual meeting for surgeons and nurses).

Mar. 9–27: Course for physicians in Occupational and Environmental Medicine, New York University Post-Graduate Medical School, New York.

Apr. 6–10: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Apr. 26–30: First International Congress on Group Medicine, Winnipeg, Manitoba, Canada.

May 7–9: Annual Meeting, American College of Sports Medicine, Albuquerque, N.M. (Exec. Secy.: Mr. Donald E. Herrmann, 1440 Monroe St., Madison, Wis. 53706).

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

Dec. 6–11: Second International Clean Air Congress, Washington, D. C.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1971 NEIGHBORING STATES

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the **Journal of the American Medical Association.**

Pediatric Dermatology—Milwaukee

A clinical meeting on *Pediatric Dermatology* will be held Nov. 8 at the Milwaukee Children's Hospital. This is jointly sponsored by the Wisconsin Dermatological Society and Milwaukee Children's Hospital.

A social hour and dinner will follow the meeting at the Milwaukee Athletic Club. Guest discussant will be Dr. Carroll F. Burgoon, Jr. of Temple University Health Sciences Center, School of Medicine, Philadelphia, Pa.

Inquiries are welcomed by R. J. Scrimenti, MD, Secretary, Wisconsin Dermatological Society, or Donald M. Ruch, MD, Dermatology Department, Children's Hospital. Address: 740 Marine Plaza, Milwaukee 53202. Tel.: 414/276–2306.

Midwest Clinical Conference—Chicago

The Chicago Medical Society's Clinical Conference has been changed to the Midwest Clinical Conference of the Chicago Medical Society, which Society officers feel is a more appropriate title since attendance comes from many other places than Chicago.

The next meeting of the Conference will be at The Sherman House, Chicago, March 1–4, 1970.

Medical–Legal Industrial Symposium

Mount Sinai Hospital, Milwaukee, will conduct its Eighth Annual Medical–Legal Industrial Symposium on "Prevention of Industrial Disease and Injury" Nov. 14 at the Hotel Pfister in Milwaukee.

Dr. Jules D. Levin, chairman, extends an invitation to all members of the industrial, legal, and medical professions.

Speakers include: Dr. Meyer S. Fox, chief of Ear, Nose, and Throat Section, Mount Sinai Hospital; Charles A. Hagberg, registered engineer and administrator of the State Division of Industrial Safety and Buildings, Madison; Clifford C. Kasdorf, attorney, Milwaukee;

Dr. Jules D. Levin, neurosurgeon and attending physician, Mount Sinai Hospital; Dr. Mischa J. Lustok, cardiologist and director of Cardiovascular Disease Center, Mount Sinai Hospital; Vincent Pollina, corporate director of safety, A. O. Smith Corporation;

Dr. James R. Regan, orthopedic surgeon and associate clinical professor of orthopedic surgery, Marquette School of Medicine, Milwaukee; and Dr. O. A. Sander, consultant in occupational medicine and clinical professor of occupational and environmental medicine, Marquette School of Medicine, Milwaukee.

Occupational Health Conferences—Wisconsin

The State Medical Society of Wisconsin, through its Committee on Occupational Health of the Commission on Health Information, will sponsor two scientific programs in the spring of 1970.

On Mar. 11 a Conference on the Provision of Occupational Health Services to the Small Industrial Plant will be held at the Racine Motor Lodge in Racine. Dr. Louis Olsman of Kenosha, a member of the Committee, will have charge of this program.

On Mar. 18 a Symposium on Farm Accidents will be held at Valhalla Hall on the Wisconsin State

"All Interns are Alike"

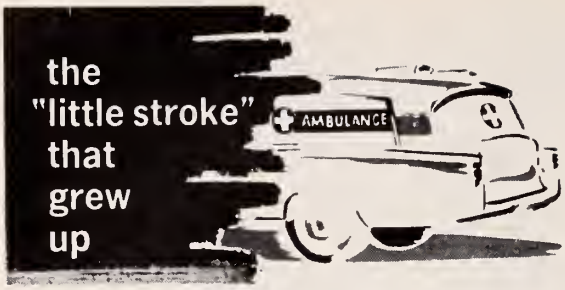
It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



prevent the progression from "little strokes" to serious cerebral vascular accident with hescor

Little strokes frequently precede the serious, often fatal Cerebral Vascular Accident. Early recognition and treatment of these "little strokes" may prevent additional cerebral damage.

Gale and Thewlis reported, "Many cerebral accidents may be avoided if adequate amounts of capillary protective factors — hesperidin complex and ascorbic acid are provided."[1]

HESCOR contains purified hesperidin — the clinically proven — biologically active, citrus bioflavonoid plus ascorbic acid. Purified hesperidin contains 80% hesperidin while hesperidin complex contains from 62% to 68% hesperidin[2]. HESCOR's higher potency assures capillary integrity.

When double vision, transitory dizziness, paresthesia or ataxia point to cerebral capillary fragility — prescribe high potency HESCOR tablets — for safe, proven protection against future cerebral vascular accidents.

hescor tablets

HESCOR contains: Hesperidin Purified, 100 mg., and Ascorbic Acid, 100 mg. Dose: for active capillary hemorrhage or threatened abortion, 2 tablets t.i.d.; for prevention of capillary hemorrhage and to maintain normal capillary function, 1 tablet t.i.d. Contraindications: none.

[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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University at La Crosse campus in La Crosse. Dr. Allen G. Brailey, Jr. of La Crosse, also a member of the Committee, will conduct this program.

Academy of Dermatology—Miami

The American Academy of Dermatology (AAD) will hold its 28th Annual Meeting Dec. 6–11 in Bal Harbour, Fla. All scientific sessions and postgraduate courses will be held at the Americana Hotel.

The AAD meeting will include two full days (Saturday and Sunday, Dec. 6 and 7) of postgraduate courses in clinical dermatology and cutaneous biology.

Special features include an all-day symposium on gross and microscopic dermatology, during which some 100 dermatologists will give short reports on rare and unusual cases; a Residents' Forum for presentation of research papers by dermatologists-in-training, and a series of breakfast and luncheon conferences and seminars on specific problems.

INFO: Frederick A. J. Kingery, M.D., Secretary Treasurer, 2250 N.W. Flanders, Portland, Ore. 97210. □

AMERICAN COLLEGE OF CARDIOLOGY CONTINUING EDUCATION PROGRAMS

1969

Nov. 3–14: Cardiology for the Consultant, Rancho Santa Fe, Calif.

Dec. 4–6: Cardiovascular Therapeutics, La Jolla, Calif.

Dec. 4–6: The Management of Problems Involving Acute Myocardial Infarction, Miami, Fla.

Dec. 8–13: Clinical Cardiology, Phoenix, Ariz.

Dec. 12–14: The Art and Science of Cardiovascular Therapy, New York, N.Y.

Dec. 12–14: Coronary Artery Disease and Cardiovascular Therapeutics, Honolulu, Hawaii.

1970

Jan. 11–13: Hypoxia, High Altitude and the Heart, Denver, Colo.

Jan. 13–14: Annual Conference on Cardiovascular Therapy—Medical and Surgical Aspects, Sacramento, Calif.

Jan. 26–30: The Physician and Intensive Coronary Care, Nashville, Tenn.

Feb. 5–6: Newer Developments in Arrhythmias: A Workshop, Irvine, Calif.

Feb. 25–Mar. 1: 19th Annual Scientific Session, New Orleans, La.

Mar. 3–4: Reconvened Annual Scientific Session, Mexico City, Mex.

FURTHER INFORMATION:

William D. Nelligan, Executive Director
American College of Cardiology
9650 Rockville Pike
Bethesda, Md. 20014

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

1.5 Million View "Drug Turn On" TV Series; Society's Work Week of Health Program

The Reason . . .

It was Dr. Robert E. Callan, State Medical Society president, who made the public pronouncement:

"There is clearcut—and frightening-evidence that drug use is increasing markedly not only in Wisconsin high schools but also at the junior grade level, and even below."

The evidence was solid, and it was piling up every day. From teachers and school administrators, from state and federal authorities, from physicians came the same story: drugs of every description were being peddled to school kids.

In a private conversation with Governor Warren P. Knowles, for instance, Chief of Police Everett Gleason of Wausau expressed the difficulty in combating drug traffic. He had found apathy and indifference from some parents. "Why don't you let the kids alone?" demanded one father to the shocked Chief. Another parent simply refused to believe his son "had the habit."

But the principal difficulty, said Gleason, "is trying to convince the young people that there is a real danger in using drugs. They've heard a dozen different conflicting stories. What is needed is an educational program that pulls no punches and from someone these kids will believe."

The State Medical Society of Wisconsin, for some time, had been working along the same line. That is why, early this month, it launched the unique "Drug Turn On," the TV special that was projected over eight state stations during the period of October 6–9.

Under the auspices of the Seventh Annual Wisconsin Work Week of Health, the program was a direct descendent of the 1968 Work Week. "Youth On a Four-Day Trip," as it was called last year, attracted some 3,300 teenagers, completely swamping the State Medical Society facilities in Madison.

"It was at the request of those teenagers," reported Dr. Callan, "plus the appalling evidence from authorities, that we decided to go statewide this year, concentrating on the grave problem of drug abuse."

Reinforcing the experience of

continued on next page

Society Opposes Psychologist Licensing Bill

A bill to license psychologists (Assembly Bill 20) was opposed by the State Medical Society at a hearing on September 20.

The Society, represented by Dr. W. T. Russell, Sun Prairie, chairman of the Commission on Public Policy, presented the view that it was opposed to the bill "in the form in which it has been submitted to the Legislature."

Dr. Russell pointed out that "while proper recognition of the psychologist is desirable, this bill would only further fragment an already fragmented approach to licensure."

The Society has offered to work with psychologists in drafting acceptable legislation, but these offers have not been accepted.

It was pointed out that the present bill does not properly identify the clinical psychologist and would "not prohibit an unqualified person from practicing." It would only "prohibit use of certain identifying words such as psychology, psychologic, and psychologists," according to Dr. Russell.

He expressed fear that the bill "does not protect the patient who is suffering from a medical condition as well as one which might require the services of a psychologist."

No action was taken at the time by the Senate Health and Social Services Committee which heard the bill.

MODERATOR—Dr. Robert E. Callan of Milwaukee, president of the State Medical Society of Wisconsin.

ON CAMERA—Dr. David E. Smith, medical director of Haight–Ashbury Medical Clinic in San Francisca.

"DRUG TURN ON"

continued

Chief Gleason, Dr. Callan stated, "Unfortunately, most adults underestimate the gravity of the problem."

"And now dangerous drugs like speed are being broadly promoted behind the mask of marijuana," he warned.

The Program . . .

DATELINE: EAU CLAIRE—MADISON—WAUSAU—GREEN BAY—ESCANABA—MILWAUKEE—DULUTH—LA CROSSE.

Those were the cities that beamed the "Drug Turn On" during the four days of the TV expedition. Viewed by approximately two of every five people, it had the largest audience of any educational program ever seen in Wisconsin.

The tone was set by the State Medical Society's president, Dr. Robert E. Callan, in his opening line: "We believe that public education is the best way to deal with drugs." His remark was echoed by every speaker during the Eau Claire telecast of 150 minutes.

Dr. David E. Smith, famed "hippie doctor" from the Haight–Ashbury Medical Clinic in California, a specialist in toxicology and psychopharmacology, defined the illegal drugs in popular use today and their chemical effects upon body and mind.

He described a typical "speed cycle" (amphetamines) before his hushed teenage studio audience of some 25. There is the almost immediate "flash"—the action phase so sought after that one girl "shot" herself 100 times in a single day.

Then follows the exhaustion phase, and an eating binge for a body starved for nourishment. Finally, the depression phase that can last a day, weeks, months.

"A person becomes trapped in this speed cycle," warned Dr. Smith, "and speed kills!" Many young people use drugs, he went on, because everyone is doing it. But finally it becomes a personal problem-solving technique.

"So that whenever a kid faces a problem, he gets 'stoned' on speed," continued the Haight–Ashbury expert. "That's his way of facing the problem. He underscored another point: "Virtually any drug they use, they will abuse." (He noted similar, widespread abuse of alcohol and cigarettes.)

Some of the TV discussion centered around existing laws on drugs. Webster Hart, former assistant district attorney of Minneapolis, singled out a legal curiosity: in this state possession of marijuana is a felony, but possession of the far more dangerous LSD is a mere misdemeanor. A redress is clearly needed, he recommended.

Also participating in the two and a half hour show was John Jungbaker, Oshkosh, Governor of Badger Boy's State.

But it was Dr. Joseph M. Tobin of the Northwest Psychiatric Clinic, Eau Claire, who startled listeners. He stated that the incidence of drug use in that area was, in his opinion, "equal to the major cities such as New York. And this serious rise in usage has occurred in just the last six to eight months."

His colleague, Dr. Gordon J. Polder of the same institute, made another telling blow: "The cry and hue we hear from youth is that they want freedom, intellectual freedom and other freedoms.

"But by using drugs illicitly," he declared, "they are actually depriving themselves of this freedom. Drugs are inhibitors."

Of considerable interest to youngsters in the audience were two of their own generation: Saul Greenberg and Deejon Bradby of Encounter, the New York-based group for youthful ex-addicts.

continued on next page

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EDITOR: Earl R. Thayer, Director of Socio–Economic Medicine.

TELECAST COORDINATOR—Mrs. Margaret Widule, program director of WEAU–TV, Eau Claire, in the control room.

EX-ADDICTS FROM "ENCOUNTER"—Deejon Bradby and Saul Greenberg of New York told of their addictive experiences during live telecasts.

"DRUG TURN ON"

continued

Greenberg is 26 years old, has been in the program for one and a half years and is a school teacher.

He told a typical story: nice middleclass family in a nice middleclass neighborhood. Life there was so inhibiting he could not "relate." That started his exploration into drugs; then he started teaching, then he started coming to class "high," then he started missing classes altogether. He refused completely to accept any responsibility; he thought society "was stupid."

Encounter, a tough organization to get into, makes you come to them. "You've got to show us something, man. We don't trust you," rang staff interviews.

Finally, one day, he answered the questions correctly. Asked what he really wanted from Encounter, he said, in a muted voice, "help." The Encounter technique was to make him yell over and over again, ever louder: "HELP! . . . HELP! . . . HELP!" It was the end of his delusions, the beginning of his road back.

Deejon Bradby is just 17, he also has been in the Encounter group about a year and a half and currently is a student at Harlem Prep.

He didn't have a nice middleclass family or neighborhood. He began with marijuana, then cocaine, "always something heavier." "If they (the family) had only communicated with me, I wouldn't have taken drugs," he confessed.

He once stayed "high" for a three-month period, never leaving his room. "All I cared about was getting high and my status in the neighborhood."

He spelled out the Encounter philosophy bluntly to the teenagers watching: "We believe that each person is responsible for his own irresponsibility. Even in an unhappy situation, you, personally, still make the decision to take drugs or leave them alone."

As "Drug Turn On" reached its dramatic end in Eau Claire, phone calls flooded the studio switchboard with 'thank yous' from deeply-moved viewers.

Said a watching newsman, "The Medical Society has done a tremendous thing today. . . ."

The Preparation . . .

The 128-year-old mandate gave the broad guideline: "to enlighten and direct public opinion in regard to the great problems of state medicine."

The phrases came from a directive by the physicians who formed the State Medical Society of Wisconsin in 1841 (seven years, by the way, before Wisconsin came into the Union as a state). It was aimed at the long line of MDs who were to follow.

Perhaps never before in Society history has a general directive been taken so literally, or executed with so much impact. The massive efforts that went into "The Drug Turn On" television series bear recounting. The preparation involved the following:

- A special task force of 12 Society members, headed by Dr. Callan.
- Personal calls upon the management of the eight TV stations that donated their air time.
- The coordination of the efforts of 41 state agencies and associations that agreed (very willingly) to assist the project. These ranged from the American Automobile Association to the Kiwanis Clubs to the Wisconsin Council of Churches to the Wisconsin Youth Council.
- A stream of informational news releases that went to 33 state daily newspapers, 287 weeklies, 112 radio stations and 17 television studios.
- Suggestions for supporting editorials also went to all news media, and they were used. The MILWAUKEE JOURNAL for example, front-paged *two* editorials it had originated to help plug "The Drug Turn On."
- A special letter to 350 local chamber of commerce executives from Kenneth W. Haagensen, ex-

continued on next page

"DRUG TURN ON"

continued

ecutive vice-president of the State Chamber, urging them to help stop "this hideous traffic" in drugs by loaning TV sets, if necessary, to schools so that youngsters could catch the program.

- A similar letter by Attorney General Robert Warren, directed to 550 chiefs of police, district attorneys, and sheriffs.
- A letter to all state senators and assemblymen and other public officials.
- A mailing of 600,000 pieces of literature, including teaching guides, Wisconsin upper-grade schools, both private and public.
- Meetings with TV directors and producers to iron out all details for a successful telecast.
- The arrangement of student audiences for the question-and-answer portions of each live TV show.
- The handling of last-minute calls from state universities for additional print materials. (6,000 to Stevens Point, for instance; 9,000 to Oshkosh.)
- Close coordination of all travel arrangements for the principals who appeared on TV.

These are merely highlights and do not detail the major assistance given the project by the Woman's Auxiliary to the State Medical Society.

The joint effort of medicine and television, said Dr. Callan, was "a great breakthrough in public service for educational purposes."

The Followthrough...

"The Drug Turn On" was an endeavor to reach nearly 509,000 Wisconsin students in grades 7 through 12.

But a TV program, however dramatic, needs followthrough to be educationally effective.

As an aid to teachers in 650 upper-grade schools, the State Medical Society sent out packets containing:

- Copies of "Guidelines for Drug Programs" by the National Institute of Mental Health. "We are a drug-using society . . ." begins the Guidelines. (And) "the best deterrent to drug abuse is the individual's value system and his assessment of the consequences associated with drug involvement . . ."
- A listing of how to obtain films, tape recordings and teaching materials on drugs. Sample film: "Escape to Nowhere." Sample booklet: "The Crutch That Cripples: Drug Dependence."
- Copies of "Drug Abuse: The Chemical Cop-Out." From the preface: "In the final analysis, playing games with the truth has historically been demonstrated to be a mistake." (With those words, Dr. Robert E. Petersen, National Institute of Mental Health, declared the need for honest enlightenment on drug abuse.)
- Copies of "The Drug Turn On," a Wisconsin Blue Shield (WPS) leaflet, on marijuana, LSD, barbiturates, amphetamines, and glue-sniffing. Its treatment of LSD (and the others) covers the subject in five telling topics:

. . . *"What Is LSD?"*
. . . *"How Is LSD Abused?"*
. . . *"What Are the Effects Of LSD?"*
. . . *"What Are The Hazards Of Experimentation?"*
. . . *"Are There Legal Controls Over LSD Use?"*

The State Medical Society has, in addition, kine films of its "Youth On A Four-Day Trip," which was the 1968 Work Week program, as well as similar radio tapes for public use.

The Society also sent all individuals involved in "The Drug Turn On" a communication urging them to "create a Community Council On Drug Abuse involving youth groups, parents, teachers, physicians, and others."

The Cooperation...

It was estimated by television marketing directors that the State Medical Society's "Drug Turn On" reached an audience of some 1.5 million people.

It was also estimated by these same experts that the public service time offered by each station would equal about $6,000 in direct outlay for loss of commercial advertising income.

The State Medical Society lists those stations in grateful appreciation:

WEAU-TV, Channel 13, Eau Claire
WKOW-TV, Channel 27, Madison
WAOW-TV, Channel 9, Wausau
WFRV-TV, Channel 5, Green Bay
WJMN-TV, Channel 3, Escanaba, Mich.
WTMJ-TV, Channel 4, Milwaukee
WDIO-TV, Channel 10, Duluth, Minn.
WKBT-TV, Channel 8, La Crosse

The Society also acknowledges the assistance of all other news media. Each played a major role in bringing the educational program to so many.

1 out of 3 PHYSICIANS

wants more information on drug abuse— for himself or his patients

To help satisfy this need, Wisconsin Blue Shield (WPS) has made available two excellent publications as part of its support for the 1969 Wisconsin Work Week of Health on the theme "The Drug Turn On." They are:

Drug Abuse: The Chemical Cop-out
and
The Drug Turn On

Both have been prepared by distinguished medical authorities. They are valuable for both medical and nonmedical readers. Single copies of "Drug Abuse" and quantity copies of "Drug Turn On" are available without cost by writing: DRUGS, Box 1109, Madison, Wis. 53701.

State District Revamping Ordered

Statewide Comprehensive Health Planning Affected

The newly created system of uniform state districts for Wisconsin is having its impact on health.

Although the system came about through action of Governor Warren P. Knowles as "an interim basis for basic statewide planning," it is expected that the district revamping will stick in some form.

All departments of state government were ordered to modify their programs and organizational setups to conform to the new boundaries. The idea is to improve the coordination of state programs and agencies and to minimize citizen inconvenience by improving the accessibility of state services.

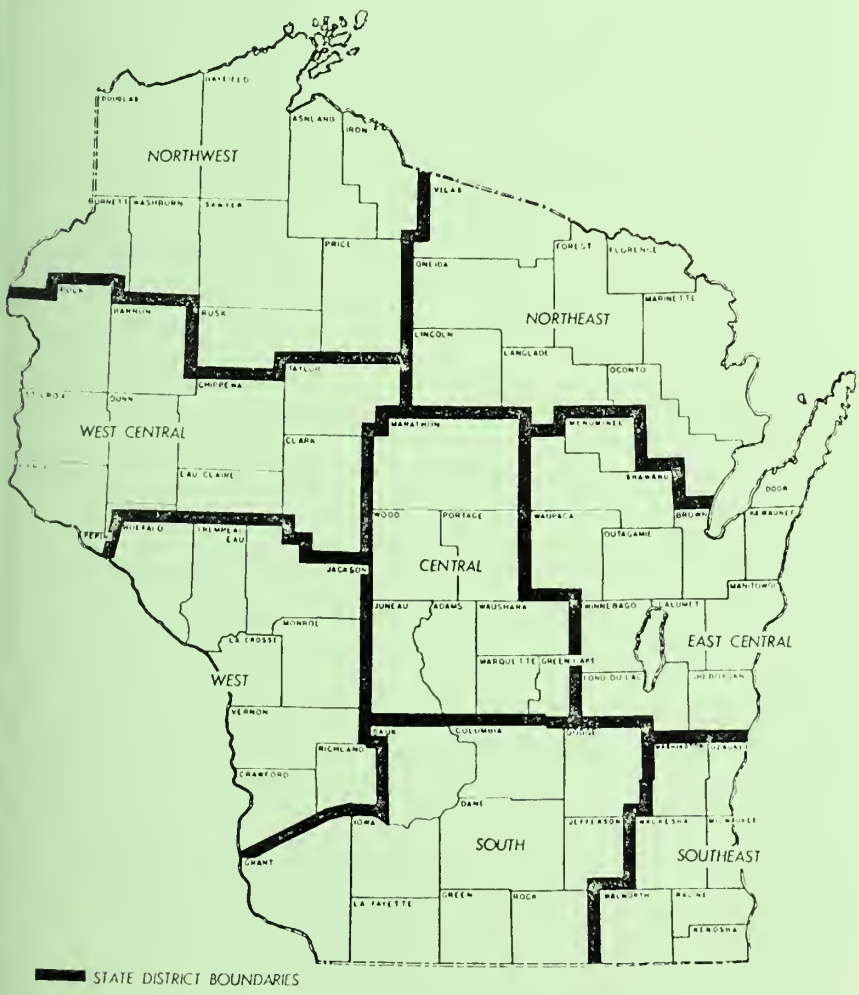
The Division of Health reports that it has realigned its district office services to comply with the order.

At the same time, the office of Comprehensive Health Planning for the state is encouraging area health planning groups to accept these regional designations.

Planning for health on the basis of certain of these districts "completely disrupts" the natural "flow of patients and health-care services," according to several physicians involved in local comprehensive health planning.

At this point, however, it appears that the only chance for change comes through a local review process established by the Governor's decree.

This provides that any county board may by resolution request a public hearing on the state district system as it affects that area. A representative of the Governor's office will conduct public hearings in the locality, on either a single county or a multi-county basis.



After the local review public hearings are completed, and after the first year's experience with the system, a thorough review of the entire redistricting plan will be undertaken.

The Governor's order indicates that after this process is completed "appropriate adjustments will be made in the subsequent Executive Order providing for final implementation of administrative districting."

Wis. Blue Shield to Administer New Drug Plan

Wisconsin Blue Shield (WPS) has been selected to administer a new plan to pay a substantial part of prescribed drug costs for employees of General Motors and their families.

With the GM plant located in Janesville, most of the employees affected are in that area. The plan went into effect October 1.

Under the plan, payment would be made for legend drugs, compounded prescriptions containing at least one legend drug, and insulin, for prescription orders and refills for which the pharmacist customarily charges more than $2.00.

The plan has a co-payment feature which means that insured persons will pay $2.00 for each prescription and refill, with Wisconsin Blue Shield paying the balance.

Prescriptions will be accepted from physicians, dentists, and podiatrists.

Medical–Legal–Industrial Symposium in Milwaukee

Mount Sinai Hospital, Milwaukee, will hold its 8th annual Symposium, Nov. 14, at the Pfister Hotel, for medical, legal, and industrial persons in an effort to teach industry how to prevent accidents and pay less insurance claims.

Registration can be made with Mount Sinai Hospital Public Relations Dept., 948 N. 12th St., Milwaukee, Wis. 53233; tel. (414) 271–2174, ext. 385.

"Spiritual" Influence Part of Total Health Care

A call for greater emphasis on the "spiritual" as part of the total health of man has been issued by the State Medical Society's Committee on Medicine and Religion.

In a letter to county medical societies in the state, the committee urges physicians with a special interest in the relationships of medicine and religion in health care to "step forward" and become active in county society programs.

"One of our goals is to establish committees on medicine and religion in each component county medical society," writes Committee Chairman Dr. John O. Simenstad, Osceola.

"The size of the committee will depend on the size of the society, but usually two to five members is adequate," he said.

Dr. Simenstad called attention to the concept that "a weakness in any one of the four factors of health—physical, spiritual, mental, or social—can and does militate toward illness in one or all three of the other factors."

The State Society's committee works closely with a similar committee of the AMA. Other members of committee are Drs. R. W. Shropshire, Madison; F. J. Cerny, Fond du Lac; J. R. Matt, Oconomowoc; and Maxwell Weingarten, Milwaukee.

The committee is planning projects involving conferences with clergy, theological seminary education, hospital chaplaincy programs, and education for medical students and nurses.

Dr. Simenstad also seeks contact with physicians who are members of the Catholic Physicians Guild, the Christian Medical Society, and the Luke Society.

Physicians interested in this subject are urged to contact John O. Simenstad, MD, Osceola, Wis. 54020; or the State Medical Society headquarters in Madison.

Physicians Urged to Document Cases Involving Water Pollution Problems

How safe is the "sky blue" water?

Now that the swimming season is over, the physicians of Wisconsin are being asked to take stock of their patient's health as it might have been affected by swimming.

The whole idea is new. There appears to be very little medical literature on the subject. Public health officials don't have information because reports aren't required, and only the most serious situations are likely to come to their attention.

The appeal for help from the practicing physicians comes from the State Medical Society's Commission on Health and Natural Resources. It is seeking to study the problems of pollution in Wisconsin as they may affect the health of its citizens.

In a letter to all Wisconsin physicians, the Commission asks their help in obtaining preliminary data on "the possibility of disease transmission and propagation in the public bathing areas of the state."

Dr. David L. Morris, West Salem, chairman of the Commission, asks the doctors to send him documentation of "any problem which you feel might be related to a potentially contaminated bathing area."

"We would appreciate any information you might have whether it be personal observations, documented infections, known irritants or allergies possibly due to algae or chemicals or any type of pollution of swimming waters. We would also like you to report the number of times your bathing area has been declared unsafe for swimming by your local health authorities," Dr. Morris writes.

All information received will be summarized in an attempt to determine the extent and types of difficulties encountered in the state.

The Commission believes the survey is important as a means of providing a more complete analysis of the safety of swimming beaches and pools in the state.

Society Supports Bill to Revamp Medical Practice Act

Despite the lull in legislative activity during a recent Capitol Hill recess, the State Medical Society pressed its program to relieve the shortage of physicians.

At a hearing in late September, the Society sought amendments to the Medical Practice Act which would ease current restrictions on the licensing of foreign-trained physicians and permit temporary licensing of physicians.

Dr. W. T. Russell, Sun Prairie, chairman of the Society's Commission on Public Policy, appeared in support of Senate Bill 583 which would revamp the Medical Practice Act.

He urged enactment of amendments to permit installment payment of medical licensing fees for residents, updating of licensing administration, and set up better procedures for dealing with foreign physicians.

Dr. T. W. Tormey, Madison, secretary of the medical examining board, said the bill would allow the state to recruit more physicians. The proposed amendments would permit temporary licensure for up to six years before a foreign physician would have to meet residency and citizenship requirements. At present these requirements must be met before any kind of license is granted.

Twenty-five percent of the State Medical Society's membership has responded to a recent survey of opinion on postgraduate scientific programs.

continued on next page

A Bus and Med Students Help Migrant Workers

Health care is a blue bus.

At least, that's what it meant to many migrant workers in the Wautoma–Plainfield area this past summer.

The "blue bus" is a mobile "health clinic" operated by University of Wisconsin medical students and volunteer physicians. It is designed to supplement local medical and hospital services in central Wisconsin when the cucumber crop brings some eight to ten thousand workers to the area from July 1 to early September.

The vehicle is a converted school bus. It has been operating in the Wautoma area for two years. The idea originated with Richard Albertini, MD, a post-doctorate fellow in medicine at the UW Medical School. Through a donation from the Wisconsin Medical Alumni Association, the bus was purchased for $350.

THE BLUE BUS—a mobile health clinic—in operation.

Students, especially those interested in the Student Health Organization (SHO), with help from the University Hospitals' maintenance crew, transformed the vehicle into a clinic on wheels . . . painted bright blue. During 1968, the blue bus made several trips to various migrant camps around Wautoma and Plainfield. Staffed by four medical students and volunteer physicians from the medical school faculty, the blue bus and its crew tried to expand the health-care service available to the migrants.

Migrant laborers are often reluctant to leave their camps for medical attention, the blue-bus staff found. Language barriers frequently hindered communications with nurses or physicians. Many of the workers lacked appreciation of the need for certain health care.

The blue-bus staff had Spanish-speaking aides who could ease the language difficulties. They encouraged reluctant workers and their families to get needed attention. They helped the workers complete and file the seemingly complicated forms needed to make them eligible for medical assistance when finances presented a major barrier.

The medical students took patient histories, helped perform laboratory studies, accompanied patients to the examining room, and aided in performing physical examinations with the attending physician.

Students maintained the clinic from 10 a.m. to 4:30 p.m. when no doctors were on duty at the bus.

University of Wisconsin, Wautoma, and Oshkosh area doctors help staff the program's clinics. Overall, the experience was educational as well as personally rewarding, wrote one student of the summer's activity.

"We were exposed to common medical problems in a less than satisfactory environment. Patient contact provided us the opportunity to gain skill and confidence," he said.

Others felt that they had made an important contribution to "helping people" by encouraging medical attention and preventive health care, handling first aid situations, and helping to solve personal problems of housing, food, and finance which are often integral parts of good health.

Newborn Institute Set for La Crosse

A Newborn Institute is set for Nov. 6 at St. Francis Hospital in La Crosse. The day-long program is one in a series sponsored by the State Medical Society's Division on Maternal and Child Welfare and the State Division of Health.

Three hours of credit for the Wisconsin Academy of General Practice requirements will be given to each general practitioner who attends.

MEDICAL PRACTICE ACT

continued

The physicians were asked especially for comments on what they most wanted in the Society's Annual Meeting program and in other scientific educational efforts.

Dr. J. A. Killins, Green Bay, chairman of the Society's Commission on Scientific Medicine, expressed appreciation for the excellent response and the "quality of many suggestions." The results are being tabulated and will be reported in a later issue of the GREEN SHEET.

SMS Hot Line

FUTURE OF MEDICAID is under serious study by a special Finch task force of which Wilbur Schmidt, Madison, director of the Department of Health and Social Services, is a member. He recently told a committee of the State Medical Society that the program is up for major revamping and there is a strong trend to put the federal government in full charge. He urged physicians with ideas on what might be done to improve Medicaid to get in touch with him.

THERE ARE NEW FACES in the regional staff of the State Medical Society. Waldemar Lindemann has been named Regional Representative for county medical societies in the northeastern portion of the state. He has previously served with the WPS sales force. In the southeastern part of the state, Jack Brown has been named Resident Representative. He was formerly with the field staff of the American Medical Association. In their new duties, both will be contacting county society officers and members.

RECOMMENDED STANDARDS for county mental hospitals are in the making through the Division on Nervous and Mental Diseases of the State Medical Society. Chairman of the Division is Dr. E. E. Houfek, Sheboygan. Watch for full report at later date.

DRUG ABUSE information programs for the community have been developed by the State Medical Society's Division on Alcoholism and Addiction under the leadership of Dr. Darold Treffert, Winnebago. Pilot projects in Appleton and Madison have been highly successful.

FACTS ON MEDICAL CARE OF AGING are being developed out of Medicare experience. Research office of Social Security Administration reports that in 1968 personal health-care expenditures from all sources amounted to $46.7 billion. One-fourth of this was spent by the aged who make up one-tenth of the population. Average annual medical bill for each person aged 65 or over was $590; for those under 65 it was $195.

CHIROPRACTIC . . . The Legislature's Joint Finance Committee has recommended that Assembly Bill 97, which would include payment for chiropractic services under Medicaid, and Assembly Bill 307, which would include payment for such services under Workmen's Compensation, be passed. The Society opposes both bills; Assemblymen should be alerted to these unwarranted attempts to expand the scope of chiropractic.

MARQUETTE MEDICAL SCHOOL . . . The Wisconsin Supreme Court has ruled that it is constitutional for the State of Wisconsin to provide financial assistance to Marquette School of Medicine, Inc. Members of the Legislature are urged to vote for legislation which would provide the necessary assistance to guarantee that Marquette will continue to operate.

trends
The Wisconsin Regional Medical Program, Inc.

OCTOBER, 1969

Duckworth Reelected WRMP Head; RAC Names Thirteen New Members

Arnett, Moeller, Lemon, Eichman, Kerrigan Named

T. A. Duckworth, senior vice-president and secretary of Employers Insurance of Wausau, Wausau, was reelected president of WRMP at the annual meeting of the Board of Directors.

Also reelected were: Edmund Fitzgerald, former president of the Northwestern Mutual Life Insurance Co., Milwaukee, vice-president; Frank E. Drew, M.D., past president, The State Medical Society of Wisconsin, Milwaukee; Orval H. Guenther, former director, Milwaukee County Institutions and Departments, Milwaukee.

The new members elected were: Eugene W. Arnett, administrator, Memorial Hospital of Taylor County, Inc., Medford, Wisconsin; Arthur C. Moeller, vice-president for academic affairs, Marquette University, Milwaukee; Wallace L. Lemon, director of planning and facilities, University of Wisconsin, Madison; Peter L. Eichman, M.D., dean, University of Wisconsin Medical School; Gerald A. Kerrigan, M.D., dean, Marquette School of Medicine, Inc., Milwaukee.

Arnett, administrator of the Memorial Hospital of Taylor County, Inc., Medford, since 1961, received his master's degree in hospital administration that same year from the University of Iowa. Prior to that he was a medical technologist at St. Joseph's Hospital, Marshfield, and St. Mary's Hospital, Wausau.

He is president-elect of the Wisconsin Hospital Association, chairman of the Public Housing Authority, Medford, member of the board of directors of Blue Cross Associated Hospital Service and a member of the Commission on Statewide Planning for Nursing Education.

Dr. Moeller, dean of the Marquette University college of engineering, was appointed vice-president for academic affairs at Marquette in 1965.

He received his undergraduate degree in 1941 from Western Reserve, and his master's degree from Michigan State University in 1948. Dr. Moeller received his doctorate degree from the University of Wisconsin.

Lemon came to the University of Wisconsin in 1963. Prior to that he served in a number of budget and management positions in Wisconsin state government, including Director of Administrative Analysis in the State Welfare Department, Director of Departmental Research in the Executive Office and State Budget Director.

Dr. Eichman, dean of the University of Wisconsin Medical School since 1965, was graduated from Jefferson Medical College, Philadelphia. He interned at Fitzgerald-Mercy Hospital, Lansdowne, Pennsylvania, and served his residency at Walter Reed Army Hospital, Jefferson Medical College Hospital, and the Mayo Founda-

(Continued on Page 4)

RAC Membership Now At Forty-Two

T. A. Duckworth, WRMP president and vice president and secretary of Employers Insurance of Wausau, has announced fifteen new appointments to the Regional Advisory Committee.

The appointments raised the number of committee memberships to 42.

New members named were:

Robert E. Callan, M.D., President, The State Medical Society of Wisconsin; Mrs. Signe S. Cooper, R.N., Wisconsin Nurses Association; Gabriel P. Ferrazzano, M.D., Commissioner of Health, Racine; Glenn Hoberg, D.O., Wis. Assoc. of Osteopathic Physicians and Surgeons; Edward J. Lennon, M.D., Marquette School of Medicine; Riley F. McDavid, President, Kenosha Memorial Hospital; Bertram N. McNamara, Director, Dist. No. 32, United Steel Workers of America; Thomas C. Meyer, M.D., University of Wisconsin Medical Center; Mrs. Anne Mills, Migrant Health Project for Marquette County; E. J. Nordby, M.D., The State Medical Society of Wisconsin, Madison; Joseph L. Ousley, M.D., Marshfield Clinic; George G. Rowe, M.D., President, Wisconsin Heart Association; Arne R. Sorlien, Luther Hospital, Eau Claire; Warren R. Von Ehren, Executive Director, Wisconsin Hospital Association.

George H. Handy, M.D., Asst. State Health Officer and Director, Division of Health, was named an

(Continued on Page 4)

WRMP Receives Award For Continuation Of Ten Projects

The Wisconsin Regional Medical Program, Inc. (WRMP), announced the awarding of a $1,064,051 grant from Washington for the continuation of ten operational projects for the next year in the areas of heart disease, stroke, and cancer. The award was $30,000 less than requested.

The announcement was made by Dr. John S. Hirschboeck, Coordinator for the program.

The continuation grant, awarded by the Division of Regional Medical Program Services, Washington, a division of the Department of Health, Education, and Welfare, authorized the continuation of the following projects:

Uterine Cancer	$105,632
Pulmonary Thromboembolism	55,404
Cancer Chemotherapy for Adults	30,500
Radiology	112,059
Coronary Angiography	5,800
Pediatric Cardiology	65,366
Cancer Chemotherapy — Milwaukee	66,725
Tissue Typing	51,350
Uterine Cytology	48,700
Inactive Nurse	60,000

Unexpended funds totaling $23,541, carried over from the 1969 budget, were also awarded for the completion of pilot programs in Nurse Shock Education and Radiology and $438,974 for support of administration, planning and medical school participation.

The award extends through August, 1970.

Sivertson, Sheldon To Ass't Coordinators

The Wisconsin Regional Medical Program, Inc. (WRMP) announced today the appointments of Sigurd E. Sivertson, University Hospitals, Madison, and Peter J. Sheldon, Marquette School of Medicine, Inc., as Assistant Coordinators for WRMP.

The announcement was made by T. A. Duckworth, president of the corporation and senior vice-president and secretary of Employers Insurance of Wausau, Wausau.

DR. SIVERTSON

SHELDON

Dr. Sivertson is the Assistant Dean of the UW Medical School and Associate Chairman of the Department of Postgraduate Medical Education and Assistant Clinical Professor of Medicine, University of Wisconsin, Madison.

Dr. Sivertson is a graduate of the University of Wisconsin, Madison, and interned at St. Luke's Hospital, Duluth, Minnesota. He then completed a fellowship at the Mayo Clinic, Rochester, Minnesota and joined the Gundersen Clinic, La Crosse, Wisconsin, as a specialist in internal medicine. He later was named Director of Medical Education and Research for the Adolph Gundersen Medical Foundation and Gundersen Clinic in La Crosse Lutheran Hospital.

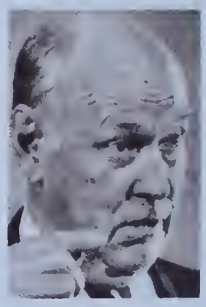
Sheldon, an Assistant Professor of Sociology in the Department of Preventive Medicine, has been with the Marquette School of Medicine Inc., since 1966. Prior to that he was Director of Community Planning with United Community Services of Greater Milwaukee.

He was graduated from the University of Wisconsin in 1948, and received his master's degree in social work from the University of Wisconsin-Milwaukee in 1952.

As Assistant Coordinators, they will be responsible for all liaison between WRMP and their respective medical facility. This includes WRMP funding as well as project programming.

HEW Ass't Head Shows RMP Support

Roger O. Egeberg, M.D., newly appointed Assistant HEW Secretary for Health and Scientific Affairs, showed his support for regional Medical Programs in a recent article in Medical World News.



DR. EGEBERG

"I feel the Regional Medical Programs have begun to lay the base for mutually respectful cooperation between the people in private practice, the hospitals in which they work, the medical schools, and the government," Dr. Egeberg is quoted. "And I thinks this is terribly important to support."

The article points out further that Dr. Egeberg will place special emphasis on developing new methods in the delivery of health care. It goes on to say that he believes Regional Medical Programs offer the government one of its best opportunities to promote innovations in delivering health care.

Dr. Pisciotta Named Tissue Typing Head

Dr. Anthony V. Pisciotta has been named Acting Program director of the Tissue Typing Program and Acting Director of the Milwaukee Blood Center.

Dr. Pisciotta succeeds Dr. S. A. Masouredis who was recently appointed Director of the Blood Bank and Professor of Pathology, School of Medicine, University of California — San Diego, LaJolla, California.

House Subcommittee Makes Recommendation On RMP Funding

The House Appropriations Subcommittee took action recently on the 1970 budgeting for Regional Medical Programs recommending to the Congress that $76,000,000 be appropriated for continued operations.

The $76,000,000 includes $24,000,000 for Chronic Disease Control programs and $2,000,000 for grants and contracts to DRMP Services. This means that, in actuality, only $50,000,000 is being recommended for the support of 55 Regional Medical Programs throughout the nation.

In a few weeks, the Senate Appropriations Subcommittee will meet. It is hoped they will recommend to Congress the full Regional Medical Program budget of $120 million as recommended by the Administration.

The Subcommittee report (No. 9-391) was submitted as follows:

Regional medical programs — The bill includes $76,000,000, a reduction of $24,000,000 from the request, and an increase of $14,093,000 above the amount appropriated for 1969. However, activities funded at the level of $21,916,000 in 1969 under the appropriation "chronic diseases" are transferred to this appropriation in 1970. Comparisons are further confused by carry-overs of funds from one year to another for which estimates are continually changing, and grants of funds in 1969 that will cover activities for 1970. The latest information submitted to the Committee indicated that there would be sufficient funds in the budget for program increases totalling $26,635,000. In recommending a reduction of $24,000,000 from the request the Committee has no intention of curtailing the regional medical programs. On the contrary the Committee strongly supports this program and is disappointed that it got started so slowly. However, fund requirements have been consistently overestimated. Of the funds available for this purpose in fiscal year 1969 approximately $20,000,000 was not used; of the amount available for the program in 1968 $36,165,000 was not used; and of the amount available for 1967 $25,900,000 was unobligated at the end of the year.

WRMP . . .

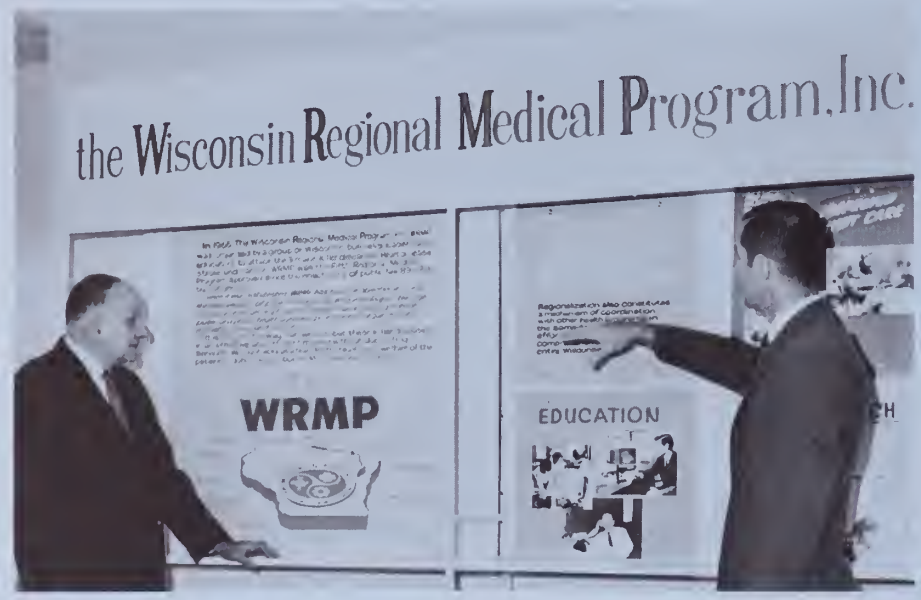
A LOOK INTO THE FUTURE

By
JOHN S. HIRSCHBOECK, M.D.
Program Coordinator

Several years ago we decided to visit the Moon, and our Government mobilized the experts to make plans to get there. Scientists and engineers, backed by our American industrial capacity, systematically worked out the master plan, and a few years later we landed two men on the Moon. So — ! ! Why can't we make our cities more livable, our air and water cleaner, and our health better? Why are we unable to muster the same determination to deal with these more mundane and yet more serious tasks?

Social planning is far more complicated than planning to go to the Moon, because it involves the attitudes and behavior of people and groups of people. It deals with firmly established and often fossilized personal, professional, or institutional interests. It may involve the remodeling of an on-going system by means of cumbersome democratic processes. Health-care planning is, perhaps, the most difficult of all social planning, because it focuses on man's incapacity and helplessness in the shadow of disease and death.

Health-care planners need encouragement and support, especially now when the health-care system is under attack because of its costliness and its inability to satisfy public demand. On the other hand, health-care planning must be relevant and must generate successful results. Theories and models in themselves are academic unless they lead to successful action. Regional Medical Programs must be action programs based on sound planning, which is truly collaborative, and which shares in the expertise of all of the professions. Most of all, health planning must have the active support of the health professions and the public, particularly in the form of constructive criticism. Without constructive criticism by the health professions, health-care planners can easily generate plans which will not or cannot work. The failure to do successful planning which has tangible results will further kindle political and public unrest which may well lead to retrogressive action in Congress.



NEW WRMP EXHIBIT — Dr. John S. Hirschboeck, left, WRMP Program Coordinator, listens as Peter A. Kirsch, Director - Public Relations, explains the new WRMP Exhibit. The exhibit is available to any organization or medical facility in the Wisconsin Region.

DUCKWORTH REELECTED

(Continued)

tion. He came to the University of Wisconsin in 1954 as a research assistant.

He is certified by the American Board of Psychiatry and Neurology and the American Board of Internal Medicine. He is a member of the American Academy of Neurology, the American College of Physicians, the American Medical Association, the Society of Clinical Neurologists, and numerous other organizations.

Dr. Kerrigan was named dean of the Marquette School of Medicine, Inc., in 1965. He was graduated from Harvard Medical School, Boston, in 1946, and served on the staff of the Massachusetts General Hospital. In 1954, he was named an instructor in pediatrics at the Harvard Medical School. He joined Marquette in 1956 as an assistant professor of pediatrics.

RAC Membership

(Continued)

alternate to E. H. Jorris, M.D., Wisconsin State Health Officer.

The prime responsibility of the committee is to advise WRMP in its operational affairs and projects for the good of the Wisconsin Region and its people.

Trends is published quarterly by The Wisconsin Regional Medical Program, Inc., 110 E. Wisconsin Ave., Milwaukee, Wis. 53202. Articles for publication can be sent to the above address in care of Director, Public Information.

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NEWS HIGHLIGHTS

Marathon Honors Dr. Clifford Kampine

More than 300 Marathon area residents turned out Aug. 3 to honor Dr. Clifford Kampine* for his 34 years of service to that community. The testimonial dinner was sponsored by several civic and service units.

During the festivities Doctor Kampine was presented with a portable television set.

The doctor was born at Appleton Aug. 17, 1903, and attended schools in Neillsville, Wausau, and Marinette.

Doctor Kampine attended the Naval Academy at Annapolis for one year after which he entered Marquette University to study law. After two years he transferred to the Marquette medical school from which he graduated in 1933.

Dr. Kampine

During his high school and college years, Doctor Kampine participated in track, basketball, and football, and today is still an ardent sports fan.

After serving his internship at Milwaukee County General Hospital, Doctor Kampine practiced medicine at Fort Sheridan and Norris City, Ill. After the death of Dr. Frank Birnbaum in 1935, he moved to Marathon and took over Doctor Birnbaum's practice. In 1958 Doctor Kampine built a medical clinic across the street from his home.

Doctor Kampine devoted many long hours to surgery at the hospital, to office and home calls. In his early years at Marathon he delivered 10 to 15 babies a month in private homes.

His wife, a registered nurse and an obstetrical supervisor before their marriage in 1932, would assist with the deliveries.

Doctor Kampine was president of the Marathon County Medical Society in 1950. In addition to membership in his county, state, and national medical societies, he belongs to the American Academy of General Practice, American College of Obstetricians and Gynecologists, and the medical staff of St. Mary's Hospital.

In December 1966, while immunizing the children at the Marathon Grade School, Doctor Kampine became ill. His medical practice has been interrupted, but while recuperating in his lake home at Minocqua, the doctor looks forward to continuing his practice when his health is restored.

Minocqua Physician and Rescue Squad Cited by Legislature

In a recent citation the Wisconsin Legislature commended Dr. J. D. Farrington* and members of the Minocqua rescue squad for their emergency care program "which provides service to the residents of Minocqua and this state and which has been recognized as an example of community service worthy of emulation."

The citation made three points:

(1) That Doctor Farrington has campaigned tirelessly for upgrading emergency care service and has been recognized as a national expert in this field;

(2) That he has helped Minocqua develop an advisory council for emergency service and a coordinated emergency care set-up which has operated for years on the volunteer services of members of the community;

(3) That this system has improved the care a victim of an accident receives at the accident scene and enroute to the hospital.

PHYSICIAN BRIEFS

Dr. Robert F. Matzke

. . . Brodhead, recently became associated with Drs. E. H. Betlach,* M. J. Roesler,* and T. R. Hansen,* Janesville, in the practice of X-ray diagnosis and therapy. He graduated from the University of Wisconsin Medical School and served his internship and received postgraduate training in radiology at General Hospital, Akron, Ohio, and Western Reserve University, Cleveland, Ohio.

Dr. John S. Honish*

. . . Oconto, recently was elected to active membership in the American Academy of General Practice.

Dr. John H. Williams

. . . recently joined the medical staff of the Marshfield Clinic. He graduated from the Indiana University and had been in private practice in Shipshewana, Ind., until 1965 when he began a residency in pathology and graduate work in Columbus, Ohio.

Dr. Kenneth B. McDonough*

. . . Madison, recently retired from the University of Wisconsin Medical School faculty which he had been associated with since 1934. He was senior teacher in the Pediatrics Department.

Dr. Joseph M. Green

. . . recently joined the staff of the Jefferson County Family Counseling Center. He graduated from Northwestern University Medical School and interned at Wesley Memorial Hospital, Chicago. Doctor Green completed his psychiatric studies at the Menninger Foundation where he received a two-year fellowship in

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Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

child psychiatry. He served three years as a clinical director for the Kansas Treatment Center for Children, Topeka, Kan. and also as a consultant to the Children's Receiving Home, Franklin County Child Guidance Clinic. Doctor Green was assistant professor of psychiatry at the University of Wisconsin Medical School for three years and until recently was in private practice in Tucson, Ariz.

Dr. Marvin E. Timm

. . . recently became associated with the medical staff of the Community Clinic, Wabasha. Doctor Timm graduated from the St. Louis University Medical School and has been interning in the St. Louis group of hospitals, including Children's City, General, and Psychiatric hospitals.

Dr. Edward R. Winga

. . . Dallas, Tex., recently joined the department of internal medicine of the Gundersen Clinic, Ltd. and La Crosse Lutheran Hospital. Doctor Winga graduated from the University of Iowa Medical School and completed his internship at the Salt Lake County General Hospital, Salt Lake City, Utah. He served in the United States Army in Korea and at Brooke General Hospital, San Antonio, Tex. Doctor Winga completed a three-year residency in internal medicine at Parkland Memorial Hospital, Dallas, followed by a year of fellowship in pulmonary diseases at Parkland and at Southwestern Texas Medical School.

Dr. John J. Ouellette*

. . . recently opened his office at the East Madison Clinic. He graduated from the University of Vermont Medical School and his internship, residency, and allergy fellowship were taken at University Hospitals, Madison. Doctor Ouellette is an instructor in medicine at University Hospitals, a diplomate of the American Board of Internal Medicine and the subspecialty Board of Allergy.

Virginia Pathologist, Medical Examiner on State Pathologists' Program Nov. 22

An all-day meeting of members of the Wisconsin Society of Pathologists will be held from 10 a.m. to 4:30 p.m. Saturday, Nov. 22, at St. Mary's Hospital in Madison. Topic for the meeting is "Forensic Pathology."

The morning program has been tentatively scheduled with the following speakers and their subjects:

Dr. Philip Piper,* Madison—*Observations in Crib Deaths.*

Dr. Roland Brown,* Milwaukee—*The Pathologist's Role in Organ Transplant from a Medicolegal Standpoint.*

Dr. Helen Young,* Greenfield—*Observations in Child Abuse Cases.*

Dr. Norbert Enzer,* Milwaukee—*The Pathologist's Preparation of Medicolegal Cases of Lung Disease.*

Dr. L. J. Van Hecke,* Milwaukee—*Deaths in Conflagrations.*

The afternoon program will be conducted by one pathologist, Dr. Geoffry Mann, LLB, MD, who will present an array of *Problem Cases in the Medical Examiner's Office.* Doctor Mann has had vast experience as the medical examiner of the State of Virginia and is a leader in this field.

As both lawyer and physician he has had extensive background in court work. The program will be rather informal with discussion throughout.

Dr. L. J. Van Hecke, program chairman, has indicated that Doctor Mann may have some comments related to the establishment of a statewide medical examiner system.

Dr. Alfred Meyers* of Milwaukee is chairman of the Scientific Program Committee of the Society.

Dr. Mullooly Is New Editor of The Linacre Quarterly

Dr. John P. Mullooly* of Milwaukee has been appointed editor of THE LINACRE QUARTERLY, official journal of the National Federation of Catholic Physicians' Guilds. The appointment took effect Sept. 1.

The periodical's chief function is to present articles on the philosophy, morals, and ethics of medical practice.

Doctor Mullooly is a specialist in internal medicine and a clinical instructor in the Department of Medicine at Marquette School of Medicine, Milwaukee.

Reared in Brooklyn, N. Y., Doctor Mullooly attended Marquette School of Medicine from which he obtained a master's degree in physiology and a medical degree.

He brings a considerable amount of experience to his new position, having been editor-in-chief of the MARQUETTE MEDICAL REVIEW during his student days. He also is a member of the Editorial Board of the MILWAUKEE MEDICAL SOCIETY TIMES.

Four Physicians Participate in Rehabilitation Seminar

Latest advances in the rehabilitation of the sick and disabled were studied by more than 250 pharmacists, nurses, and physiotherapists at the 1969 Fall Seminar, sponsored by Sickroom Services, Inc., Oct. 7 and 8 at the Pfister Hotel in Milwaukee.

Four physicians participated on the program: Dr. Fred F. Johnston, medical director, Respiratory Therapy Department, and associate of the Cardio-Pulmonary Institute, Methodist Hospital, Dallas, Tex.; Dr. Leonard F. Bender, professor, Department of Physical Medicine and Rehabilitation, University of Michigan Medical School, Ann Arbor;

Hospital Removes Cig Machine

St. Luke's Hospital in Milwaukee recently joined other area hospitals in removing cigaret vending machines from its facilities. The action was taken "in view of growing medical evidence that smoking is injurious to health and at the encouragement of the Wisconsin Hospital Association," explained Lowell M. Vandervort, hospital administrator.

1 OUT OF 3

PHYSICIANS WANTS MORE INFORMATION ON DRUG ABUSE—FOR HIMSELF OR HIS PATIENTS

To help satisfy this need, Wisconsin Blue Shield (WPS) has made available two excellent publications (shown above) as part of its support for the 1969 Wisconsin Work Week of Health on the theme "The Drug Turn On." Both have been prepared by distinguished medical authorities. They are valuable for both medical and nonmedical readers. Single copies of "Drug Abuse—The Chemical Cop-Out" and quantity copies of "The Drug Turn On" are available without cost by writing: DRUGS, Box 1109, Madison, Wis. 53701.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
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Usage In Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

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Milwaukee Hospital Provides On-job Training for Army Medical Corpsmen

A full-dress United States Army Reserve drill at St. Francis Hospital, Milwaukee, Sept. 7 formally opened a unique on-the-job training program the hospital has undertaken in cooperation with the 452nd General Hospital, U. S. Army Reserve Unit, Milwaukee.

St. Francis is believed to be the first private hospital in Wisconsin to cooperate with an army reserve unit in such a program. Actual medical–surgical training is provided for the corpsmen, who train at the hospital in teams composed of two Army nurses and six corpsmen each.

Over 60 nurses and corpsmen performed the drill, which was followed by a brief program.

Three Milwaukee physicians participated in the program: Brig. Gen. Leo R. Weinshel,* Whitefish Bay, former commanding officer of the Unit and present commanding general of the 801st Hospital Center in Chicago; Col. C. A. Bauer,* Milwaukee, commanding officer; and Col. Julius M. Meyer,* Milwaukee, chief of professional services and chief of internal medicine at the hospital.

Sister M. Paschalisa, administrator, accepted for the hospital a presentation made by Gen. Weinshel. Sister M. Teresilda, director of nursing service, explained details of the hospital training.

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Dr. George R. Barry, Monroe, New Internists' President

Dr. George R. Barry,* Monroe, was installed as president of the Wisconsin Society of Internal Medicine during the group's annual meeting Sept. 11–14 at Lake Delton. He succeeds Dr. James W. Manier* of Marshfield.

Eighty-five physicians from the state attended the meeting which included a two-day scientific program.

Doctor Barry is past chairman of the Society's membership committee and has served on the Society's medical practice, constitution & bylaw, and program committees. He has been a director of the Society since 1963.

Others elected were: Dr. Addis C. Costello,* Milwaukee, president-elect; Dr. John M. Irvin,* Monroe, secretary–treasurer; and Dr. Robert E. Madden,* Milwaukee, on the Society's Governing Council.

Army Promotion, Dr. Pawsat

Dr. John E. Pawsat, a 1965 graduate of the University of Wisconsin Medical School, Madison, and a son of Dr. and Mrs. E. H. Pawsat* of Fond du Lac, recently was promoted to Army major while serving as an orthopedic surgeon in Vietnam.

Medicare Beneficiaries

. . . who incurred reimbursable medical expenses during 1968 must file claims for reimbursement on or before Dec. 31, 1969.

Drs. Royden F. Collins*

. . . Richard J. Hennen,* Don R. Janicek,* George N. Kerrihard,* John A. Salick,* Bernhardt E. Stein,* Jacob K. Tweeten,* and Walter L. Washburn,* Madison, recently were reelected to active membership in the American Academy of General Practice. Other physicians reelected from Wisconsin were: Drs. Reuben N. Burch,* James L. Nolan,* Waukesha; James R. Kuzdas,* Louis S. Stern,* West Allis; Richard E. Housner,* Kilian H. Meyer,* Richland Center; Herbert A. Dasler,* O. N. Arneson,* Amery; and Herman R. Thomas, Jr.,* Fond du Lac.

Drs. Lowell R. Graves

. . . Crookston, Minn., James T. Curry, Freeport, Ill., and Hans A. Kneubuhler,* Wisconsin Dells, recently joined the medical staff of The Monroe Clinic. Doctor Graves, who will head the new department of oral surgery, took his fellowship in oral surgery at the Ochsner Clinic Foundation, New Orleans, La. Doctor Curry, who joins the department of surgery, graduated from the University of Illinois Medical School and recently completed a two-year fellowship from the American Society in connection with the University of Illinois. He is certified by the American Board of Surgery. Doctor Kneubuhler graduated from the University of Wisconsin Medical School and received a fellowship in metabolism at Milwaukee County General Hospital and most recently was affiliated with the Wood Veterans Administration Hospital, Wood, and Medical Associates of Menomonee Falls. All three physicians have served in the United States Armed Forces.

Dr. Frank L. Myers*

. . . Madison, recently joined the staff of the Davis–Duehr Eye Clinic, Madison. Doctor Myers graduated from the University of Iowa Medical School, served his internship in Oakland, Calif.,

spent two years in the United States Navy, and was in general practice for four years. He was a resident in ophthalmology at the University of Wisconsin and received a one-year fellowship in diseases of the retina from the National Institutes of Health.

Dr. Robert H. Caplan

. . . Chicago, recently became associated with the Gundersen Clinic, Ltd. and Lutheran Hospital, La Crosse, in the department of internal medicine. Doctor Caplan graduated from the University of Chicago and served a rotating internship at Highland–Alameda County Hospital, Oakland, Calif. He completed a three-year residency in internal medicine at the University of Colorado and served in the United States Army Medical Corps for two years. Doctor Caplan was a United States Public Health Service fellow in endocrinology and an instructor in the department of internal medicine at the University of Chicago before coming to La Crosse.

Dr. Eugene E. Herzberger*

. . . formerly of The Monroe Clinic, Monroe, recently moved to new offices in Madison. He was a neurologist at Yale University and instructor in neurosurgery at the Medical College of Georgia before joining The Monroe Clinic.

Dr. Timothy J. Donovan*

. . . Madison, recently began practice at the Dean Clinic, as an ear, nose, and throat specialist. He graduated from the University of Wisconsin Medical School and took his internship at Wayne County General Hospital, Eloise, Mich. Doctor Donovan's residency was taken at the University Hospitals, Madison.

Dr. Charles D. Brummitt

. . . recently became associated with the Wilkinson Clinic, Oconomowoc, in the practice of general medicine. Doctor Brummitt graduated from the University of Iowa and interned at The Gen-

UW Regents Approve New Profs

An August announcement by the University of Wisconsin Board of Regents of promotions to tenure positions of professor and associate professor included 33 doctors in the medical school.

Associate professors named professors are: James R. Allen, pathology and Primate Research Center; John W. Anderson, anatomy; Alvin L. Berman,* neurophysiology; George T. Bryan,* clinical oncology; Carl H. Fellner,* psychiatry; Stanley Inhorn,* pathology and preventive medicine;

Robert O. Johnson,* clinical oncology and administration; A. L. Kennan, gynecology and obstetrics; Robert L. Metzenberg, physiological chemistry; Elizabeth C. Miller, oncology; Flavio Puletti,* surgery;

H. J. Sallach, physiological chemistry; Howard Temin, oncology; Kenneth Thompson, gynecology and obstetrics; and Gabrielle Zurhein, pathology.

Assistant professors named associate professors are: Gene M. Abroms,* pyschiatry; Edward A. Azen, medicine; Edna M. Cree, medicine; Larry D. Davis, physiology; Robert W. Edland,* radiology; Jack Grabow,* neurology; Stanley Graven* and Mark F. Hansen,* pediatrics;

Sanford Mackman,* clinical oncology; John A. Mangos, pediatrics; John Opitz, genetics and pediatrics; Richard F. Rieselbach, medicine; Warner V. Slack, medicine and computer sciences; W. Stuart Sykes, anesthesiology;

Charles A. Tait, rehabilitation medicine and communicative disorders; Bernard Weisblum, pharmacology; and Charles E. Yale,* surgery.

Dr. Heidelberger Honored

A nationally renowned cancer researcher from Madison was honored recently by the Milwaukee Chapter of Hadassah.

Charles Heidelberger, PhD, a member of the University of Wisconsin faculty, received the Myrtle Wreath Achievement Award in recognition of his outstanding achievements in chemotherapy and cancer research.

Hadassah, the Women's Zionist Organization of America, was founded in 1912 to aid the Jews in Palestine. Its chapters in the U.S. work to operate and maintain the Hadassah–Hebrew University Medical Center in Jerusalem, and conduct and support child care and land reclamation work in Israel.

Dr. A. A. Siebens Wins First Place for Exhibit

Dr. Arthur A. Siebens* of the University of Wisconsin, Madison, was awarded the first place Gold Award for his exhibit, "Gravity vs. Spina Bifida," at the 46th annual meeting of the American Congress of Rehabilitation Medicine in Chicago Aug. 11–14.

The annual award recognizes scientific developments presented in especially effective exhibit form to help increase knowledge and improve practice in the specialized field of rehabilitation medicine and related professional services for disabled people.

EPILEPSY FOUNDATION OFFERS FELLOWSHIPS

The Epilepsy Foundation of America is offering a number of undergraduate and graduate student fellowships in epilepsy amounting to $300 per month and not exceeding $900 per student.

Students' programs may be in either a clinical or laboratory setting related to the general field of epilepsy and preferably in a setting where research in the field of epilepsy is being undertaken.

Applicants should submit a letter briefly outlining their background, interest, and reasons for applying for the fellowship; an outline of their proposed program; and, a letter from a preceptor who will be responsible for the program.

Letters should be addressed to: Fellowship Program, Epilepsy Foundation of America, 733—15th St. NW, Washington, D. C. 20005. Application deadline is Feb. 1, 1970.

Walworth Special School to Have Pool

The mentally retarded children of the Walworth County Special School in Elkhorn will have an indoor swimming pool this fall.

An "overwhelming" response by swimming pool equipment manufacturers to donate equipment and services has made the pool project possible, said J. Henry Mohr, president of the National Swimming Pool Foundation.

"The Walworth School continues to be one of the most important midwest centers for research in the teaching of these unfortunate children," Mohr added.

The pool is part of a new 34,000 square foot extension of the existing school facility.

William J. Lewis, director of the school's special services, notes that in Elkhorn, "a very limited portion of the populace has the opportunity to take part in any swimming activity whatsoever." The pool would serve the whole community, he said.

The Walworth county home and farm, serving the aged retarded and mentally ill (21 years of age and older), the Physical Therapy Department of the Elkhorn hospital, and about 2100 children in the Elkhorn public and parochial school system will benefit from the pool as well as the more than 250 students in the Special School.

The pool project was originally brought to the attention of Merle Dowd, the National Swimming Pool Foundation's director of communications, by Julien U. Stein, director of the Project on Recreation and Fitness for the Mentally Retarded, part of the American Association for Health, Physical Education and Recreation in cooperation with the Joseph P. Kennedy, Jr. Foundation.

Mohr and Dowd worked closely together in gaining support from industry to furnish the facility which they believe is an appropriate and necessary project for the Foundation to assist.

INTERNATIONAL SURGERY ANNOUNCES

Journalism Award for Surgical Residents

International Surgery, official journal of the International College of Surgeons, is announcing a cash award of $500.00 for the best scientific paper submitted by a surgical resident. The award is being made available through a grant from Carroll J. Bellis, M.D. Dr. Bellis is a Fellow of the International College of Surgeons and practices general surgery in Long Beach, California.

Details are as follows:

Award: Cash prize of $500.00.

Offered To: Residents in general surgery or any of the surgical specialties in any country.

Subject Area: Topics should stress the clinical aspects of surgical science.

Rules: Scientific articles being entered must be original and must not have appeared elsewhere in print. Articles must be typewritten, double-spaced and submitted in duplicate.

Bibliographies should be presented alphabetically, cover all references cited in manuscript and contain the following information: Names and initials of all authors; full title of article or book; name of book's publisher, city and year published; name of periodical, volume number, page and year of publication.

All illustrations should have the following on the back: Author's name, figure number and the top clearly indicated. Captions must accompany illustrations and the approximate position in the text for the illustrations should be indicated. Slides are not acceptable. Captions for photomicrographs should give magnification and stain.

Deadline: November 30, 1969.

How To Submit: Surgical Resident Award Program, International Surgery, 1516 N. Lake Shore Drive, Chicago, Illinois 60610.

eral Hospital, Fresno, Calif. He served in the United States Air Force for two years and has been in the general practice in Taylorville, Ill., where he was also chief of staff of St. Vincent's Hospital.

Dr. James C. Opitz

. . . recently became associated with the pediatric staff at the Marshfield Clinic. He graduated from the University of Nebraska College of Medicine and interned at St. Benedict's Hospital, Ogden, Utah. Doctor Opitz took his residency at Wilford Hall Hospital, San Antonio, Tex., and prior to joining the Marshfield Clinic, he had practiced medicine at the U.S. Air Force Academy, Colo.

Drs. Lester P. Brillman,*

. . . Cyril M. Carney,* and William A. Pruett,* Beloit, have been reelected to active membership in the American Academy of General Practice.

Dr. M. J. La Breche

. . . recently established a new practice in the Madison and Monona area. A graduate of the Marquette School of Medicine, Milwaukee, he will specialize in general practice and obstetrics.

Dr. David F. Sweet

. . . joined the staff of The Sheboygan Clinic under a locum tenens arrangement until June 30, 1970, when he will begin a residency training program in ophthalmology at Marquette University. The doctor received his medical degree at the University of Minnesota School of Medicine in 1966, and served his internship at San Bernardino County General Hospital, Calif., the following year. He was in the U. S. Air Force from 1967 to 1969.

Dr. James E. Conley*

. . . Milwaukee, was moderator of a Cardiovascular Forum Session at the Ninth International Congress of The International Cardiovascular Society in Buenos Aires, Argentina, Sept. 25–27.

Drs. A. C. V. Elston

. . . and Fred A. Schaldach recently joined the staff of the Gundersen Clinic, Ltd., and La Crosse Lutheran Hospital.

Doctor Elston graduated from the University of Wisconsin Medical School in 1964 and served his internship and a year of pediatric residency at La Crosse Lutheran Hospital. He completed his pediatric training at the University of Colorado Medical Center, Denver. He was awarded fellowships for training in pediatric cardiology from the Colorado Heart Association and the National Institutes of Health.

Doctor Schaldach graduated from the University of Wisconsin Medical School in 1961 and interned at St. Luke's Hospital, Duluth, Minn. He served two years in the United States Public Health Service, Division of Indian Health, working among the Sioux Indians in North Dakota. In 1964, he returned to the Gundersen Clinic for one year of surgical fellowship. He recently completed four years of surgical training in the Marquette affiliated surgical residency program.

Dr. Donald W. Smith

. . . Madison, recently attended the International Union Against Tuberculosis meeting held in New York City. He presented a report on Collaborative Evaluation of Test Systems for Assessing Tuberculosis Vaccines.

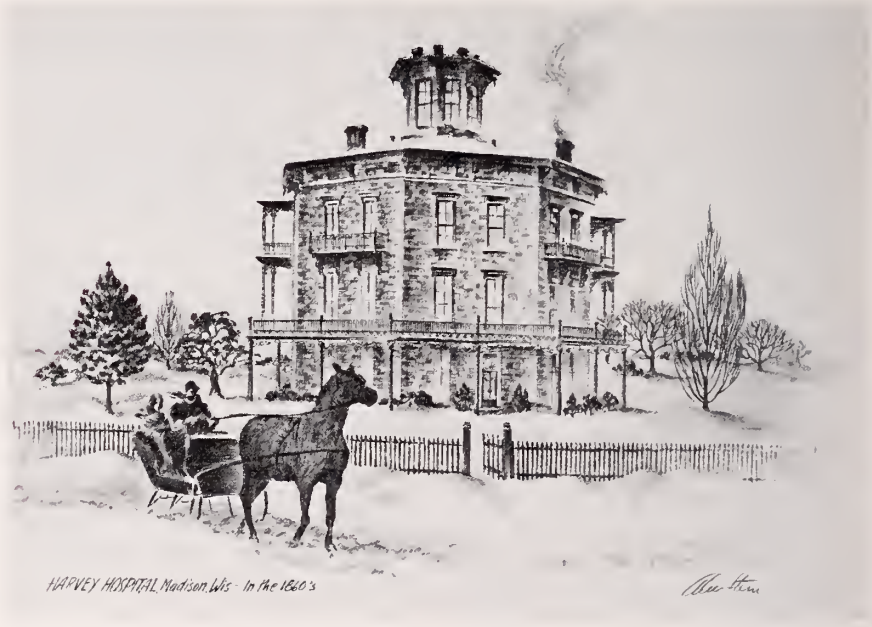
Dr. Gerald W. Wadina*

. . . Cudahy, recently joined the medical staff of Trinity Memorial Hospital, Cudahy. Doctor Wadina graduated from Marquette School of Medicine and interned at UCLA affiliated hospitals in Los Angeles. He received three years of training in eye diseases and eye surgery at Marquette affiliated hospitals, Milwaukee.

Dr. John McKenzie*

. . . of Oshkosh and Dr. William Hildebrand* of Menasha were speakers at the Winnebago County Medical Society meeting Sept. 4 in Oshkosh.

Christmas Cards



HARVEY HOSPITAL

At the corner of Spaight and Brearly Streets in Madison is a plaque reading:

> "On this city block, during the Civil War, stood Harvey Hospital, and later the Wisconsin Soldiers' Orphans' Home, both established through the influence of Mrs. Harvey, whose honored husband, Governor L. P. Harvey, had accidentally been drowned in the Tennessee River, at Pittsburg Landing, Tenn., near the Shiloh battlefield, April 19, 1862, where he had gone after the battle, with supplies for the comfort of the sick and wounded Wisconsin soldiers."

Mrs. Harvey personally succeeded in convincing President Lincoln to use the octagonal limestone mansion of former Wisconsin Governor Leonard J. Farwell for soldiers of the State wounded in the Civil War. For her efforts, Mrs. Cordelia Harvey came to be known as "The Wisconsin Angel."

A Special Project of the Woman's Auxiliary

TO THE STATE MEDICAL SOCIETY OF WISCONSIN

This holiday greeting benefits the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

Box of 25: **$5.00** NAME IMPRINTED ON REQUEST (at an additional cost)

ORDERS MUST BE RECEIVED BY NOV. 15

SEND ORDERS TO: **Woman's Auxiliary to the State Medical Society of Wisconsin Box 1109, Madison, Wis. 53701**

Be sure to include quantity desired and the name to be imprinted if desired.

CONTRIBUTIONS—CES FOUNDATION

July 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1969:

Nonrestricted

State Medical Society	Voluntary contributions of 25 MDs
Mr. and Mrs. Earl R. Thayer	Memorial: Ralph P. Sproule, MD
James V. Bolger, MD	Memorial: Ralph P. Sproule, MD
J. Victor Bolger, MD	Memorial: Ralph P. Sproule, MD
Robert E. Callan, MD	Memorial: Ralph P. Sproule, MD
Dr. and Mrs. W. D. James	Memorial: Ralph P. Sproule, MD
Dr. and Mrs. W. D. James	Memorial: Thomas Lubitz
Wisconsin Medical Journal	Memorial: Mrs. Charles Pollack
State Medical Society	Memorial: F. W. Hammond, MD
State Medical Society	Memorial: T. H. Nammacher, MD
State Medical Society	Memorial: C. W. Aageson, MD
State Medical Society	Memorial: M. C. Malensek, MD
State Medical Society	Memorial: Adam A. Beck, MD
State Medical Society	Memorial: Ralph P. Sproule, MD
State Medical Society	Memorial: Gorton Ritchie, MD
State Medical Society	Memorial: Frank E. Rettig, MD
State Medical Society	Memorial: Fred A. Nause, MD
Dr. and Mrs. Henry C. Rahr	Memorial: Mrs. Frank Zachek
Professional Association for Civic Education (PACE)	Memorial: Ralph P. Sproule, MD
Mr. and Mrs. James F. Miller	Memorial: Mrs. Charles Pollack

Museum of Medical Progress

State Medical Society	Voluntary contributions of 2 MDs

Student Loans

State Medical Society	Voluntary contributions of 2 MDs

Donations Other Than CESF Projects

State Medical Society	Voluntary contributions of 4 MDs

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

Danforth Student Loan Fund

Mrs. Quincy H. Danforth	Contribution

History of Nursing in Wisconsin Exhibit

The Heil Company	Contribution
Irvin E. Gaynon, MD	Contribution
John C. Cleaver	Contribution
Richard R. Teschner	Contribution
Signe S. Cooper, RN	Contribution
Mr. and Mrs. George L. Kuehn	Contribution
E. R. Squibb & Sons, Inc.	Contribution

NATIONAL EMPLOY THE PHYSICALLY HANDICAPPED WEEK OCTOBER 5–11, 1969—AND THEREAFTER

The handicapped worker has not only shown himself to be a good and competent employee; he frequently brings something extra in the way of motivation. He tries harder because he wants to show what he can do. As a result, employment of the handicapped is no longer regarded as an act of compassion; it is a matter of good business judgment. — THOMAS J. WATSON, JR., Chairman of the Board, IBM Corp.

Dr. David Hilton

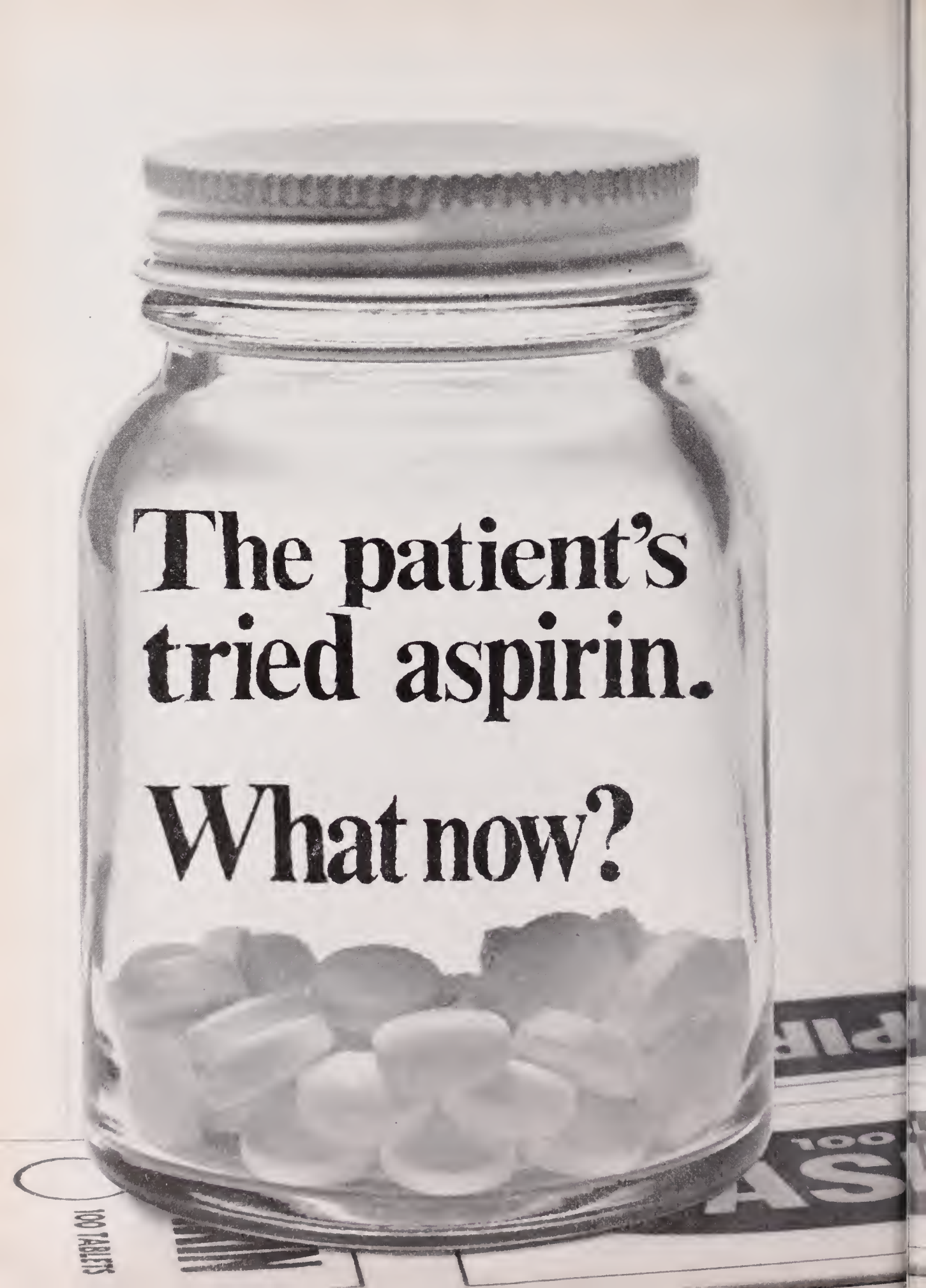
. . . on Sept. 2 became associated with the Red Cedar Clinic in Menomonie. He and his family returned to this country June 21 after spending 10 years in Nigeria. Doctor Hilton served as a missionary with the United Methodist Church in the African country where he performed medical work in a 110-bed hospital. A native of Rochester, Minn., he received his medical degree in 1957 from the Indiana University Medical School. He interned one year at Gorgas Hospital in the Panama Canal Zone and took one year of surgical residency at Harris Hospital, Fort Worth, Tex., before leaving for Nigeria. Wisconsin was his preference when returning to the U.S.

Dr. Robert L. Kollmorgen

. . . recently joined the staff of The Sheboygan Clinic in the department of general surgery. He is a graduate of the University of Nebraska and received his resident training at the Iowa Methodist Hospital in Des Moines from 1965 to 1969. Doctor Kollmorgen served his internship at the Kansas City General Hospital and Medical Center in Missouri. He previously completed two years of service with the U.S. Public Health Service as Chief Medical Officer, 14th Coast Guard District, in 1964 and 1965.

Dr. Karl A. Briester

. . . a Green Bay psychiatrist, has joined the staff of the Northwoods Guidance Center in Rhinelander on a one-day-per-week basis. The Center serves Forest, Oneida, and Vilas counties. Doctor Briester is a graduate of Marquette University School of Medicine, Milwaukee, and received residency training at County Hospital, Fresno, Calif., and State Hospital in Traverse City, Mich. He has been in private practice in Green Bay since July 1967. He also serves as a consultant to other mental health agencies in the northern Wisconsin area.


The patient's tried aspirin.
What now?
100 TABLETS

There's a good chance your patient needs more than a non-prescription analgesic for pain relief. Especially after self-medication has failed.

Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . *and* associated anxiety and tension.

Tablets

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

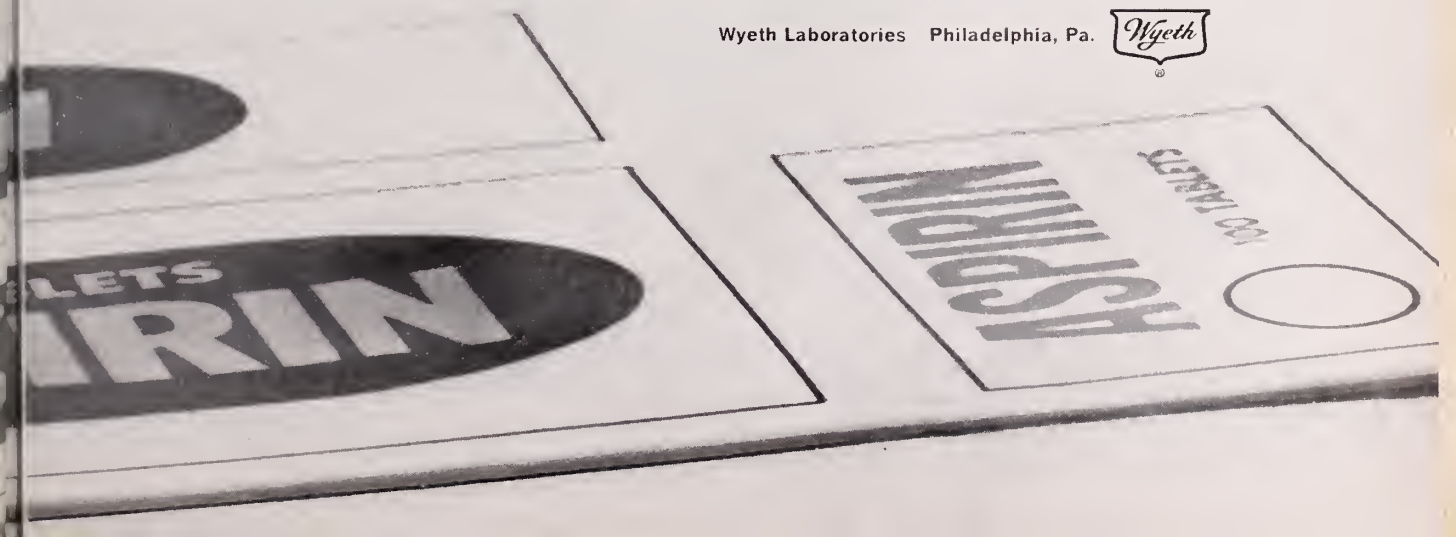
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



Dr. K. M. Zarka

. . . opened the Silver Lake Medical Center Sept. 15 after many years of searching for a doctor by the Silver Lake community. Dr. Chester DeWitt,* who has been serving the community for over 30 years, was the prime instigator for community support in obtaining another doctor. Doctor Zarka received most of his medical training in Germany and served his internship at West Suburban Hospital in Oak Park, Ill. Prior to one year's service at the Hazel Green Clinic in Wisconsin, the doctor spent five years as emergency room physician as well as taking psychiatric training at the mental health department in Illinois.

Drs. Paul J. Ambro*

. . . Kenosha; Richard J. Bryant,* Durand; Samuel S. Sorkin,* Evansville, and Waldemar W. Wolfmeyer,* Kaukauna; recently were reelected to active membership in the American Academy of General Practice.

Drs. Julio De Arteaga*

. . . Brillion; Glenn C. Hillery,* Lancaster; Clayton I. Ingwell,* Deerfield; Earl J. Netzow,* Lake Mills; Vincent W. Nordholm,* Stoughton; Nathaniel G. Rasmussen,* Dodgeville, and Clarence A. Topp,* Clintonville, recently were reelected to active membership in the American Academy of General Practice.

Dr. R. J. Murphy

. . . Green Bay, recently joined the new Deckner Medical Center staff in Green Bay. He graduated from the University of Wisconsin Medical School in 1962 and took his internship at St. Mary's Hospital, Duluth, Minn. Doctor Murphy was stationed in Japan as a medical officer in the United States Navy for four years, and for the past four years he has been a resident physician at Milwaukee County Hospital, taking his specialty training in obstetrics and gynecology.

Council on Cardiovascular Nursing Formed by American Heart Association

The American Heart Association has announced the establishment of a Council on Cardiovascular Nursing to disseminate reliable information in the field and help achieve the Association's objectives for improved patient care.

The new Council will consist of registered professional nurses affiliated with Heart Associations in their local communities. Initial $5 dues will cover the period from July 1, 1969 through Dec. 31, 1969. Thereafter, dues will be $5 yearly.

The Council on Cardiovascular Nursing is an outgrowth of the Heart Association's Committee on Nursing Education. The first business session of the Council will be held in Dallas on Nov. 15 as part of a scheduled two-day Clinical Nursing Conference to be conducted in conjunction with the Association's annual Scientific Sessions.

Membership application forms and additional information on the Nursing Council may be obtained from the Wisconsin Heart Association, 205 West Highland Ave., Milwaukee 53203, or from Katharine A. Lembright, RN, Assistant Director, Department of Medical Education, American Heart Association, 44 East 23rd Street, New York, N.Y. 10010.

"Care of the Dying" Seminar, Marshfield

A seminar on "Care of the Dying" was held Sept. 25 in Marshfield, co-sponsors being the Marshfield Area Clergy Association, St. Joseph's Hospital, and the Marshfield Clinic Foundation for Medical Research and Education.

Dr. G. M. Abroms,* director of inpatient psychiatry at the University of Wisconsin Medical School, Madison, spoke on "The Doctor, the Dying Patient, and the Bereaved."

Doctor Abroms joined several others in a panel discussion moderated by Dr. Francis N. Lohrenz* of the Marshfield Clinic. Physicians on the panel were Dr. W. H. Heywood* of the Marshfield Clinic psychiatric staff and Dr. J. L. Ousley,* Clinic internist.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF SEPTEMBER 1969

2	Dane County Medical Society Board of Trustees
3	Advisory Committee to State Alcoholism Service
3	SMS Commission on State Departments
5	Committee on History of Nursing in Wisconsin, Wisconsin Nurses Association
8	Dane County Health Planning Council
10	Advisory Committee on Health Careers, Wisconsin Health Council
10	Board of Directors, Wisconsin Health Council
11	Legislative Advisory Committee, Wisconsin Association of Professions
13	SMS Maternal Mortality Study Committee and Division on Maternal and Child Welfare
16	Madison Area Dietetic Association
17	SMS Commission on Safe Transportation
17	Wisconsin Regional Medical Program Staff
18	Ninth Councilor District, Wisconsin State Dental Society
19	Community Health Planning Institute, Wisconsin Nurses Association
20	Wisconsin College Health Association
20	SMS Commission on Medical Care Plans
24	Professional Nurse Registration Examinations
25	Professional Nurse Registration Examinations
25	SMS Commission on Hospital Relations and Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the lacation in parentheses.

Wisconsin Medical Assistants Hold Professional Advancement Seminar

About 70 members of the Wisconsin State Medical Assistants Society attended a Professional Advancement Seminar at the Sheraton–Schroeder Hotel in Milwaukee on Saturday, Sept. 27.

Formerly called the Leadership Training Seminar, the ability of leadership was incorporated into the overall program of professional advancement. For the first time subjects that would influence, improve, and streamline all spheres of their lives were united in this seminar.

Mr. Shiedler Harp, assistant director of Officers Service, American Medical Association, Chicago, presented an introduction to public speaking. This included audience involvement and the encouragement of beginners in the adventure of public speaking.

Mr. Donald D. Henninger, clinic manager of the Courtland Medical Center, Milwaukee, spoke on the delegation of work and personnel rapport.

A "workshop" pertaining to organizational responsibilities for present and potential officers, committee chairmen, and members was also presented.

Miss Catherine Fuhrman, CMA, Milwaukee, was chairman of the seminar.

Marquette-Jackson Clinic Have 39th Annual Meet

Guest physicians at the 39th Annual Marquette–Jackson Clinic Postgraduate Meeting held Sept. 25 at the Park Motor Inn, Madison, received generous doses of diversified medical information during the afternoon and a message from Wisconsin's attorney general in the evening.

Approximately 100 physicians attended the afternoon scientific session, followed by a social hour and dinner for doctors and their wives. Attorney General Robert W. Warren was the dinner speaker.

Speakers from the Marquette School of Medicine faculty were Dr. James E. Youker,* professor and chairman of the Division of Radiology, who spoke on "Lymphangiography," and Edward H. Olson, assistant professor in the Division of Psychiatry, who discussed "The Impact of Serious Illness on the Family System."

Jackson Clinic speakers and their topics of discussion were Dr. Vaughn E. Demergian,* plastic surgeon, "The Needy and the Greedy;" a talk on the treatment of breast disorders; Dr. Gordon A. Tuffli,* pediatrician, "Recognition and Management of Common Genetic Syndromes;" Dr. Allen J. Pois,* cardiovascular surgeon, "Cardiac Pacemakers: A Study in Human Physiology;" and Dr. Hubert V. Moss,* dermatologist, "Diagnosis and Management of Acute Skin Disorders."

The fall Marquette–Jackson Clinic programs date back many years to their origin by Dr. Arnold S. Jackson, late head of the Jackson Clinic in Madison, and former Dean Eben Carey of Marquette School of Medicine in Milwaukee.

Dr. Luther E. Holmgren* is current president of the Jackson Clinic. Co-chairmen of the postgraduate meetings are Drs. Blake E. Waterhouse* and William B. Parsons, Jr.*

Speakers at Public Forum on Arthritis

Dr. Warren K. Simmons,* internist of Rhinelander, and Dr. William Norton,* Wausau orthopedic surgeon, were featured speakers at a free public forum on arthritis held Sept. 17 in Eagle River.

Dr. E. M. Schmidt*

. . . of Berlin has closed his office and will work in the area of public health and pharmaceutical research in Wisconsin.

Dr. J. L. Weygandt*

. . . Sheboygan Falls, has been reappointed to the state highway safety advisory council by Gov. Warren Knowles. Doctor Weygandt is chairman of the Commission on Safe Transportation of the State Medical Society.

Dr. E. H. Jorris*

. . . Madison, state health officer, has been reappointed to the state highway safety advisory council by Gov. Warren Knowles.

Dr. Robert Shapiro

. . . child psychiatrist of Madison, now spends two days per week at the Counseling Center of Sauk, Juneau and Richland counties. He also is affiliated with Madison Psychiatric Associates where he is in private practice. Doctor Shapiro received his medical training at the Downstate Medical Center in New York. His residencies in psychiatry and child psychiatry were taken at the Menninger Clinic in Topeka, Kan.

Dr. G. Thomas Pfaehler

. . . a psychiatric resident in Madison, spends one day per week at the Counseling Center of Sauk, Juneau and Richland counties. He received his medical training at the University of Wisconsin Medical School and served his internship at Madison General Hospital.

Dr. Joseph J. Mazza

. . . Rochester, Minn., recently joined the medical staff at the Marshfield Clinic. Doctor Mazza graduated from Loyola University, Chicago, and served his internship at Cook County Hospital, Chicago. He has been at the Mayo Clinic, Rochester, Minn., since his discharge from the 2nd Marine Air Wing in 1965.

Pertofrane® desipramine hydrochloride

Indication: Mental depression.

Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal.

When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants.

Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm.

Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold).

Desipramine and the parent compound, imipramine, have been shown to block the action of guanethidine and related adrenergic neuron-blocking agents.

Hypertensive episodes have been observed during surgery.

The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures.

Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery.

Do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk, and do not use in patients under 12 years of age.

Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients.

Precautions: Potentially suicidal patients require careful supervision and protective measures during therapy. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement.

Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents).

Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances.

Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy.

Adverse Reactions: The following have been reported: *Nervous System*: dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract*: anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin*: skin rashes (including photosensitization), perspiration and flushing sensations. *Liver*: rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements*: bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System*: orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System*: urinary frequency or retention and impotence. *Endocrine System*: occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity*: urticaria and rare instances of drug fever and cross-sensitivity with imipramine.

Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily.

Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response.

Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated.

Availability: Maroon and pink capsules of 50 mg. in bottles of 100; pink capsules of 25 mg. in bottles of 100 and 1000. (B)46-530-G

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Coming out of a depression.

And it can often begin to happen in 3 to 5 days with an antidepressant like Pertofrane. There's a lifting of depressed mood . . . a restoration of psychomotor activity. Patients usually begin to cope, work, maybe play, even enjoy.

It's not all beautiful. Sometimes there are side effects. And not everybody can take the drug. It may even be a slow process. But along with the care and comfort you give depressed patients, consider Pertofrane. Then consider the respons

Please read the prescribing information for full details on contraindications, warnings, precautions, adverse reactions and dosage. It's summarized on the left.

Pertofrane®

desipramine hydrochloride

New 50-mg. capsules now available.

It's beautiful!

Dr. Edward H. Olsen, Jr.*

. . . recently joined the faculty at Marquette School of Medicine, Department of Psychiatry, on a full-time basis. Doctor Olsen had been engaged in private practice in West Bend before completing his residency at the University of Wisconsin Medical School.

Dr. Parnell Donahue*

. . . Hales Corners, recently became associated in the pediatric practice of medicine with Drs. John J. Czajka* and John F. Alstadt.* Doctor Donahue graduated from Marquette School of Medicine and served his internship at St. Joseph's Hospital and completed his pediatric residency.

Dr. William W. Moir*

. . . Sheboygan, received a "21-gun salute" August 4 when his 41-foot ketch made port after a 4,000-mile and 41-day voyage from England. Doctor Moir purchased the yacht in The Netherlands and he and his crew of University of Wisconsin students set sail across the Atlantic. The salute was offered by the Ely, a naval reserve training ship stationed in Sheboygan. About 200 persons were on hand when the yacht docked. Doctor Moir reported no major problems during the voyage, but complained of the weather which remained cold during the entire voyage. Doctor Moir is a radiologist at Sheboygan Memorial Hospital and a widely known yachtsman. His son, William III, a senior at the University of Wisconsin in Madison, was among the crew.

Dr. Nancy Wu*

. . . and Dr. Nalda Thung,* assistant professors of anesthesiology, University of Wisconsin Medical School, Madison, attended the Postgraduate Medical Assembly of South Texas, July 21–24, in Houston. They presented their exhibit, "Effects of Anesthesia and Surgical Operations Upon Respiratory Function."

Plymouth Welcomes New Doctors

A welcome dinner for new Plymouth doctors plus an appreciation night for physicians serving the area was held August 28 at the Plymouth high school.

The event was planned by Doctors for Plymouth, Inc., a civic organization responsible for obtaining two new physicians.

The new physicians are Dr. Franz Gutowski, who formerly practiced in Wishek, N. D., and Dr. Shapoor Ansari, an Iranian who was given approval to practice in Wisconsin by special legislation.

A third doctor, William G. Treviranus, D.O., recently joined the Plymouth Clinic. He is a native of Plymouth.

Other area doctors included in the affair were: Drs. R. J. Alvarez,* L. J. Steffan,* H. A. Weisse,* A. J. Brickbauer,* and J. F. Mueller of Plymouth; Dr. John E. Martineau* of Elkhart Lake; Drs. J. L. Weygandt* and Horace J. Hansen* of Sheboygan Falls. Physicians from Kiel and Random Lake and Adell's new doctor, Jose Tolentino, were also invited.

"Drug Dialogue" Starts in Madison

A public program aimed at finding the answers to questions that both young people and adults have about drugs started in Madison Sept. 18.

Dr. Darold Treffert,* superintendent of Winnebago State Hospital and chairman of the State Medical Society's Division on Alcoholism and Addiction, lead the discussion.

Service clubs, youth groups, church groups, and civic and governmental organizations, including both young people and adults, were asked to send representatives to this initial meeting.

After the first meeting, young people and adults who were willing to invest the time were trained as discussion panelists to carry the program to PTAs, service clubs, and other interested groups. Training meetings were held Sept. 25 and Oct. 2.

The Madison program is based on a similar project at Appleton where a 90-member task force—30 adults, 30 high school students, and 30 college students—were trained to appear on panels leading the discussion and answering questions about drugs.

Sponsors of "Dialogue on Drugs" include Ad Hoc Citizens Committee on Drug Information, Attic Angel Association, Dane County Association for Mental Health, Dane County Medical Society, Dane County Mental Health Center, University of Wisconsin Division of Student Affairs, Madison East Kiwanis Club, and Madison Junior Chamber of Commerce.

UW Receives Hartford Foundation Grant

Continuation of University of Wisconsin research on the causes and management of the respiratory distress syndrome in premature infants was made possible recently by a grant from the John A. Hartford Foundation, Inc., New York City.

The UW Medical Center's Department of Pediatrics was given $158,975 for a three-year study.

The research will be carried on in the Hartford Neonatal Research Laboratories at St. Mary's Hospital in Madison.

Head of the program is Dr. Stanley N. Graven,* associate professor of pediatrics at Wisconsin.

Named to CHP Committee

Dr. Margaret Hatfield, Elkhorn, has been elected permanent chairman of the Walworth County Comprehensive Health Planning Resource Committee.

The committee will work with other county committees in setting up a regional planning program of health-care services and facilities in Southeastern Wisconsin.

Surgical Society Has Fall Meeting

Dr. Kenneth L. Carter* of Beloit, president of the Wisconsin Surgical Society, presided at the morning scientific session of the Society's fall meeting Sept. 13 at St. Joseph's Hospital in Marshfield.

In the afternoon Dr. Charles S. Rife* of Milwaukee, president-elect, presided.

Speakers and their topics follow:

Drs. Richard Burg* and Sanford Mackman,* Madison, *Clinical Experience with the Soave Procedure for Congenital Megacolon.*

Dr. Mahmood Mirhoseini,* Wausau, *Operative Coronary Arteriography.*

Dr. Wayne Boulanger,* Milwaukee, *Celiac Axis Angiography.*

Dr. Eugene Eckstam,* Monroe, *Chronic Venous Insufficiency.*

Dr. Louis Phillip,* Green Bay, *Pancreatic Pseudocysts.*

Dr. Robert Benneyan,* Fond du Lac, *Gallstone Ileus.*

Drs. James Gutenberger and John Pellett,* Madison, *Clinical Experience with Intravenous Hyperalimentation.*

Dr. William Gallagher,* La Crosse, *Ligation Treatment of Hemorrhoids.*

Dr. Jerry McRoberts,* Sheboygan, *Affairs of the State Medical Society.*

Dr. Gilbert Mueller,* Appleton, *Arteriovenous Fistula—Case Report.*

Dr. George Pratt,* Rhinelander, *Carpel Tunnel Syndrome.*

Dr. A. Erik Gundersen,* La Crosse, *Surgical Repair of Collapsing Trachea in Infants.*

Dr. Fred Bunkfeldt,* Milwaukee, *Pasteurella Multocida Infections in Animal Bites.*

Dr. B. J. Longley,* Madison, *Problems of A–V Shunts for Renal Dialysis.*

Drs. H. Myron Kauffman, Jr.,* William Rogers, and Donald J. Kuban,* Milwaukee, *Illogicity of the Logistics of Cadaver Renal Transplantation.*

Dr. Robert S. Monk,* Waukesha, *The Dictates of Herniorrhaphy Technique—Judgments of Anatomical Variations.*

Drs. Richard Burg* and Sanford Mackman,* Madison, *Use of a Reversed Jejunal Segment for Post Vagotomy and Gastroduodenostomy Diarrhea.*

Dr. Donald E. Koepke,* Milwaukee, *An Unusual Case of Tetralogy of Fallot.*

Dr. Ben R. Lawton,* Marshfield, *Translumbar Amputation.*

The program was prepared by Dr. Donald E. Koepke,* Milwaukee, and his Program Committee. Dr. Ben R. Lawton was chairman of the local arrangements in Marshfield.

Medical Care Workshop Set for Nov. 21–22

A two-day workshop on "Delivery of Medical Care in the 1970's" has been arranged by the Institute of Medicine of Chicago for Nov. 21–22 at the Ambassador Hotel, Chicago.

Among the noted speakers are Robert M. Ball, Commissioner, Social Security Administration; and Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare.

WISCONSIN SCOREBOARD

DRINKING • DRIVING • DEATH

MOTOR VEHICLE DRIVER DEATHS REPORTED, 1968

DEATHS	DECEMBER	JAN. thru DEC.
Total Deaths Reported	31	423
No. With Alcohol Involved	19	275
Percent	61.3	65.0
No. With Alcohol at or Above .15% (Legal Intoxication Level)	15	148
Percent	48.3	34.9

Compiled by the State Division of Health

Dr. Thomas C. Meyer*

. . . chairman of the Department of Postgraduate Medicine of the University of Wisconsin Medical Center in Madison, participated in a national conference on the use of audiovisuals in medical education, in Birmingham, Ala., August 6–8. The goal of the conference was to resolve some of the disparity which exists among medical educators in their knowledge and utilization of audiovisual aids as educational tools and to define the role of the learning resource centers as they relate to medical education centers and hospital environments.

Dr. Wallace G. Irwin*

. . . Lodi, recently was reelected chief of staff at Divine Savior Hospital, Portage. Drs. T. S. Westcott,* Pardeeville, vice-president, and Stewart F. Taylor,* Portage, secretary and treasurer, will remain in office for another year.

Doctors Reelected to AAGP

The following physicians recently were reelected to active membership in the American Academy of General Practice. They are: Drs. James Connolly,* Thorp; Frederick W. Gissal,* Wisconsin Dells; Kenneth L. Haman,* Waupaca; Phillip A. Heiser,* Woodville; Wallace G. Irwin,* Lodi; William A. Nielsen,* West Bend; John J. Rouse,* Reedsburg; Donald M. Rowe,* Kohler; Joseph A. Russell,* Random Lake; Milton F. Stuessy,* Platteville; Marwood E. Wegner,* St. Croix Falls; Louis W. Weisbrod,* New Richmond; James L. Weygandt,* Sheboygan Falls, and Forrest E. Zantow,* Oconto.

Dr. Thomas M. Zurkowski

. . . Beloit, recently became associated with the Medical Associates of Beloit. He graduated from Creighton University School of Medicine, Omaha, Neb., in 1966 and served as an intern and member of the staff of the United States Public Health Service Hospital, Baltimore, for three years.

Dr. Jose DeLeon

. . . Boyceville's new physician, is practicing in the Municipal Hall basement which has been transformed into a new community medical clinic. The community had been without a physician since 1953. A temporary license to Doctor DeLeon was granted him by the state legislature and Governor Knowles in May. Doctor DeLeon is a 1955 graduate of the University of Santo Tomas Medical School, Manila, the Philippines.

Dr. Eileen H. Levis

. . . Tomah, recently joined the medical staff of the Tomah VA Hospital. Doctor Levis graduated from the National University of Mexico and for the past three and one-half years has been in general practice in Warner, N. H. She served her internships at Grey Nuns' Hospital in Regina, Saskatchewan, Canada, and at Memorial Hospital in Pawtucket, R. I.

Dr. James Esswein

. . . Chetek, recently joined the staff of the Chetek Medical Clinic. Doctor Esswein received his medical training at University of Wisconsin Medical School and interned at Marshfield. He spent two years in the Public Health Service at Clinton, Okla., and the past year has been spent in residency at the University of Wisconsin.

Dr. Richard L. Eders

. . . Prairie Village, Kansas, recently became associated in practice with Dr. L. M. Baertsch,* Hayward. Doctor Eders graduated from the Kansas University Medical School, Kansas City, Kansas and completed his internship and participated in a surgical program at Menorah Medical Center, Kansas City, Mo.

Dr. Edward McCormack*

. . . Niagara, recently was honored as Niagara's Citizen of the Year at the annual community picnic. □

CONTRIBUTIONS—CES FOUNDATION

August 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1969:

Nonrestricted

State Medical Society	Voluntary contributions of 6 MDs
David N. Goldstein, MD	Memorial: Mr. Irving Silverberg
E. J. Nordby, MD	Memorial: Ralph P. Sproule, MD
Paul Weise	Memorial: Sheri Twiss
State Medical Society	Memorial: Kilian T. Bauer, MD

Museum of Medical Progress

Clifford A. Olson, MD	Contribution
Terrance Goerne	Contribution

Student Loans

Thomas J. Doran	Contribution

Danforth Student Loan Fund

Mrs. Quincy H. Danforth	Contribution

History of Nursing in Wisconsin Exhibit

Cornelia Van Kooy Memorial Trust Fund	Contribution

Tuberculosis Exhibit

Wisconsin Anti-Tuberculosis Assoc.	Contribution

Scientific Teaching

Merck, Sharp and Dohme	Contribution

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorial: Orville Edgerton

G. W. Hilliard, Jr., MD—Fellowship Fund

State Medical Society	Contribution

Popp Student Loan Fund

Albert Popp, MD	Contribution

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

Foundation Administers Dr. Houghton Medical Student Award

Outstanding medical students in Wisconsin are honored each year by the State Medical Society as a result of an endowment of the late Dr. John H. Houghton, Wisconsin Dells.

The first awards, administered by the Society's CES Foundation, were presented in May 1968 to James D. Renne, UW senior medical student from Kenosha and C. Robert Stanhope, Marquette senior medical student from Milwaukee. Each received a plaque and a $100 cash award.

Doctor Houghton established the award in early 1968 to honor students who "through scholastic excellence, extra-curricular achievement and interest in the activities of medical organization show high promise of becoming a 'complete physician.' "

Doctor Houghton served as Society president in 1965–66. Since his death, Doctor Houghton's initial endowment has been increased to nearly $6,000 by memorial gifts by many who knew him. □

PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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A·H·ROBINS

OBITUARIES

Dr. Robert A. Scheidt, 43, director of laboratories at St. Luke's Hospital, died Aug. 5, 1969, in Milwaukee.

Born on Feb. 23, 1926, in Chicago, Ill., Doctor Scheidt graduated from the University of Chicago and Loyola University Medical School. He interned at St. Joseph's Hospital, Marshfield, and practiced in Seneca, Ill., before coming to Wisconsin. Doctor Scheidt practiced in the Milwaukee area for nine years. He was a member of the Royal Academy of Sciences and was a fellow in the American College of Pathologists and in the Society of Clinical Pathologists.

Doctor Scheidt was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Mary; and five children, Mary Patricia, John, David, Karl, and Robert.

Dr. Mark A. Bailey, 90, Fennimore, died Aug. 8, 1969, in Fennimore.

Born on May 26, 1879, in Fennimore, Wis., Doctor Bailey graduated from the Bennett Medical School, Chicago, Ill., in 1903. In 1965 he retired after 62 years of practice in Fennimore, where he was known as the dean of Grant County's physicians. Doctor Bailey served in the United States Army in World War I and in 1953 he was honored as a "50-year club" member of the State Medical Society of Wisconsin.

He was a member of the Grant County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Irma, and a son, Mark, Danville, Ill.

Dr. Wilmer C. Edwards, 73, Richland Center, died Aug. 23, 1969 in Richland Center.

Doctor Edwards was born on Feb. 19, 1896 in Spring Green, Wis. He completed the first two years of medical training at the University of Wisconsin, Madison, and graduated from the Rush Medical College, Chicago, Ill., in 1924. He took his internship at Evanston Hospital, Evanston, Ill., and came to Richland Center in 1925 where he practiced for over 42 years. Doctor Edwards was the founder of the Edwards Clinic which merged with the Richland Medical Clinic in 1967. He was a fellow of the American Academy of Obstetrics and Gynecology and delivered over 5,000 babies in the Richland Center area. He was the author of several articles on obstetrics and gynecology as practiced in a rural area.

Dr. Edwards

Doctor Edwards was a member of the Richland County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Lucille; two daughters, Mrs. Jack (Louise) Carson, Charleston, Mo., and Mrs. James (Marilyn) Tydrich, Richland Center; and a son, Dr. Richard, Richland Center.

Dr. Joseph R. Franco, 65, chief of continued treatment at the Tomah Veterans Hospital from 1949 to 1964, died Aug. 5, 1969, in Elmhurst, Ill.

Surviving is his widow, Patricia; and a son, Richard. □

FILM: FEDERAL GOVERNMENT AND CANCER

The Federal Government and Cancer, a new 20-minute 16mm motion picture is now available. It is a panel presentation of timely information on cancer management and cancer research programs supported and directed by the government.

Members of the panel discussing the programs are Drs. Laurance V. Foye, Jr., chief of the Clinical Investigations Branch, Extramural Activities of the National Cancer Institute, J. Palmer Saunders, associate director, Extramural Activities of the National Cancer Institute, C. Gordon Zubrod, scientific director for Chemotherapy at the National Cancer Institute, and Margaret H. Sloan, associate director for Organizational Liaison, Division of Regional Medical Programs, Department of Health Education and Welfare.

The film was produced during the recent meeting of the American Radium Society at Philadelphia. It was made to help doctors interested in cancer management understand the kinds of programs supported and encouraged by the government, and how they are administered.

Prints may be borrowed from the American Medical Association film library, 535 North Dearborn, Chicago, Illinois 60610, or at the National Medical Audio Visual Center, Atlanta, Georgia 30333. □

ROLE OF WORK EVALUATION UNITS COVERED IN NEW PUBLICATION

The proceedings of the Third National Conference on Work Evaluation Units, held in November, 1966, are now available from local Heart Associations or the AHA National Office.

Under co-sponsorship of the American Heart Association, the Vocational Rehabilitation Administration, and the Heart Disease Control Program of the U.S. Public Health Service, the Conference was attended by professional personnel interested in cardiac rehabilitation.

Included in the program were a critical review and discussion of the significance of the psycho-social and vocational aspects of work evaluation units; informal discussions of administrative and professional problems in the units; a session on the educational role of the units; and discussions on the relationship of the units to federal Regional Medical Programs and other community agencies.

The proceedings are of special interest to physicians in industrial practice and rehabilitation, rehabilitation counselors, psychiatrists, psychologists and social workers.

WISCONSIN HEART ASSOCIATION: 205 West Highland Ave., Milwaukee, Wis. 53203; tel. 414/272-4246. □

He Had a Big Hand . . .

Richland Center has been fortunate in having a group of well trained and well equipped doctors. . . .

One of the big reasons, of course, for the situation is The Richland Hospital, an institution that was established by interested men and women of the area. . . .

The death of Dr. Wilmer Charles Edwards last Saturday brought to a close the career of the last of the pioneer doctors who contributed greatly to the success of The Richland Hospital and the reputation of the city as a medical center.

Dr. Edwards opened his practice here in 1925, only a year after The Richland Hospital was opened as a 14-bed facility. Through the years that he practiced in Richland Center, he has had a big part in helping it to grow to the size and the importance that it now has for the people of Richland Center, Richland county, and the surrounding area.

A dedicated, conscientious, and hard-working physician, Dr. Edwards acquired for himself a strong reputation and a constantly increasing family of patients. This, of course, made it necessary for him to establish a small clinic of his own, and following World War II, he brought several outstanding young doctors to this community. He was asked to lecture to Medical School students, strong testimony for his accomplishments.

Himself a Phi Beta Kappa, the highest academic honor a student can earn, Dr. Edwards had a particular interest in education. Because of it, he served with considerable distinction, also, as a member of the School Board. It was during his period of service that the board was called upon to lead the district through one of its most critical periods. He, also, was especially aware of his responsibilities as a board member to the students of his school. Many times, he would find out from the athletic coach if an injury had occurred in a game on the day or night before. Always, in case there was one, that would be the first call he made in the morning. his was a service that he felt was his duty, and never was a charge made for it.

Dr. Edwards was also continually aware of the life of the community. He was a long-time member of the Kiwanis club and took his turn at leading the club in its program of service, particularly to underprivileged children. Interested in young people and in other countries, Dr. and Mrs. Edwards were the first hosts, upon their own initiative and expense, to an American Field Service exchange student. They had two of these students, with both of whom they kept continual contact and whom they were planning to visit again this fall.

The strongest indication of Dr. Edwards' real deep feelings, his appreciation for his community, his teachings, his leadership, and his influence lies in the fact that what he has done in his 44 years of medical practice in Richland Center will continue to have its effects upon the community and its people for many years.

What greater monument to a man can be made than to have a member of his own family carry on the work that he has started?

Dr. Edwards has that in two of the outstanding young doctors of the community, a son, Dr. Richard W., and a son-in-law, Dr. James J. Tydrich.

Dr. Edwards had a big hand in the lives of so many.

—Reprinted from the Richland Center Observer, Richland Center, Wis.

★

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF SEPTEMBER 11, 1969

NEW MEMBERS

Ameduri, Ardow, 1649 Park St., Middleton 53562
Brennan, John T., 4146 County Club Rd., Madison 53711
Buchler, Dolores A., 1300 University Ave., Madison 53706
Carnesale, Peter G., 223 Wisconsin Ave., Waukesha 53186
Hebble, William M., 1146 Grant St., Beloit 53511
Jaeger, John G., 4317 Crawford Dr., Madison 53711
Kraft, John W., 925 Mound St., Madison 53715
Lindblade, James A., 2 West Gorham St., Madison 53703
Linden, Robert E., 5534 Medical Circle, Madison 53711
Matzke, Robert F., 1431 Ruger Ave., Janesville 53545
McIntyre, James A., 408 South River St., Janesville 53545
Murley, Harris D., 1227 Dartmouth Rd., Madison 53711
Olsen, Clark O., 1313 Fish Hatchery Rd., Madison 53715
Owen, Russell H., 1300 University Ave., Madison 53706
Storms, William W., 6333 Pheasant Lane, #A19, Middleton 53562

REINSTATED

Lappley, Walter F., 1708 Main St., Cross Plains 53528

CHANGES OF ADDRESS

Allen, Maurey, Madison, to 3635 South Newport Way, Denver, Colo. 80222
Baker, Robert M., Jr., 314 Virginia Terr., Madison 53705
Barnes, H. P. G., 5714 Odana Rd., Madison 53711
Batson, John R., 5714 Odana Rd., Madison 53711
Belson, Michael J., 923 Eliza St., Green Bay 54301
Bjornson, Jon, 31 South Mills St., Madison 53715
Bourne, Charles W., APO, San Francisco, Calif., to 3460 North Summit Ave., Milwaukee 53211
Brunkow, Benjamin H., 523 St. Clare Ct., Monroe 53566
Crow, Robert W., Milwaukee, to 691 Moreland Dr., Pittsburgh, Pa. 15243
Donovan, Timothy J., 1313 Fish Hatchery Rd., Madison 53715
Downes, Virginia, Cherokee, Ia., to Yale University School of Medicine, Dept. of Community and Social Psychiatry, New Haven, Conn. 06520
Granzeau, Herbert W., 190 Gardner Ave., Burlington 53105
Grossman, Ronald E., 7110 North River Rd., Milwaukee 53217
Gregorski, Robert F., Milwaukee, to School of Aerospace Medicine, Brooks AFB, Tex. 78235
Haller, Carol A., Milwaukee, to 1460 Sandburg Terr., Chicago, Ill. 60610
Harper, David G., Madison, to 334 Kenilworth Ave., Duluth, Minn. 55803
Helm, Frederic C., Milwaukee, to 7237 North Oleander, Chicago, Ill. 60648
Herzberger, Eugene E., Monroe, to 1605 Monroe St., Madison 53711
Huber, Herman H., 3909 North Murray, Milwaukee 53211
Kindwall, Joseph A., 4606 North Woodburn St., Milwaukee 53211
Knezevic, Ivan, 20 South Park St., Madison 53715
Kolner, Edward H., 5714 Odana Rd., Madison 53711
Kusterman, John A., 2605 North Frederick Ave., Milwaukee 53211
Kuwayama, S. Paul, Milwaukee, to N 82 W 15401 Appleton Ave., Menomonee Falls 53051
Lim, Robert A., Milwaukee, to 17510 Sierra Lane, Brookfield 53005
Majewski, Joseph T., Milwaukee, to P. O. Box 379, West Bend 53095
Malueg, Thomas J., Appleton, to 1028 Surrey Ct., Neenah 54956
Manhart, Richard A., Elm Grove, 6333 Landfall Dr., Madison 53705
Martin, Don H., 409 East Silver Spring, Milwaukee 53217
Masouredis, Serafeim P., Milwaukee, to University of California, San Diego, Basic Science Bldg., Room 1023, La Jolla, Calif. 92037
Matthews, G. C., 1920 West Hart Rd., Beloit 53511
McCabe, Lloyd B., Silver Springs, Md., to U. S. Army Hospital, Fort Jackson, S. C. 29207
Miller, David F., 745 Kenney Ave., Eau Claire 54701
Miller, George E., 745 Kenney Ave., Eau Claire 54701
Mills, John M., 923 Eliza St., Green Bay 54301
Moore, James N., 5714 Odana Rd., Madison 53711
Nadeau, E. George, 923 Eliza St., Green Bay 54301
Nadeau, Emile G., 923 Eliza St., Green Bay 54301
Nelson, W. L., 240 Shore Acres Dr., Wisconsin Rapids 54494
Nickelsen, J. R., 823 Perry Ave., Racine 53406
Olson, Ernest S., 1728 Carlisle Ave., Racine 53404
Paetkau, Margaret E., Madison, to 9408—143rd St., Edmonton 51, Alberta, Canada
Pellegrino, Ernest A., Jr., Madison, to 124A Polaris, Sheppard AFB, Tex. 76311
Peterson, William G., 20 South Park St., Madison 53715
Popp, Mark J., Milwaukee, to 17000 West North Ave., Brookfield 53005
Randall, John H., Aurora, Colo., to 1821 South Webster, Green Bay 54301
Samter, Thomas G., Milwaukee, to 5029 North Lake Dr., Whitefish Bay 53217
Schaefer, Etheldred L., Madison, to St. Mary's Hospital, Rhinelander 54501
Schimanek, T. A., 3601 Alpine, Madison 53704
Schmidt, E. M., Berlin, to c/o Hubert Wargula, Neshkoro 54960
Schnapp, A. C., 7227 North 115th St., Milwaukee 53224
Schwaegler, Robert R., 1920 West Hart Rd., Beloit 53511
Shields, John C., 2521 Paris Angel Dr., La Crosse 54601
Slocumb, C. O., Hermosa Beach, Calif., to 228—9th St., Manhattan Beach, Calif. 90266
Stein, B. E., 5714 Odana Rd., Madison 53711
Terner, Elizabeth Anne, Green Bay, to 19 Avalon Rd., Waben Newton, Mass. 02168
Turrell, Eugene S., Milwaukee, to Apt. 410, 1333 Jones St., San Francisco, Calif. 94109
Urlakis, Kenneth J., Arlington Heights, Mass., to 6509 West Washington Blvd., Wauwatosa 53213
Varma, Som D., New Berlin, to W337 S4451, Deer Park Rd., Dousman 53118
Washburn, W. L., 5714 Odana Rd., Madison 53711
Watry, Theodore D., 3173 South 35th St., Milwaukee 53215
White, Ellison F., Racine, to 553 East Madison St., Houston, Miss. 38851
Witt, Darrell L., Bobbs, Mont., to 1403 Wilson Ave., Menomonie 54751

REMOVED FROM MEMBERSHIP

Aguilar-Sincaban, V. M., Dane County, resigned

DEATHS

Franco, Joseph R., nonmember, Aug. 5, 1969
Scheidt, Robert A., Milwaukee County, Aug. 5, 1969
Bailey, Mark A., Grant County, Aug. 8, 1969
Edwards, Wilmer Charles, Richland County, Aug. 23, 1969
Burns, Robert E., Dane County, Sept. 8, 1969

Photo professionally posed.

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Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOK REVIEWS

STEREOSCOPIC ATLAS OF MASTOIDOTYMPANOPLASTIC SURGERY

By Harold F. Schuknecht, M.D., professor of otology and laryngology, Harvard Medical School; Werner D. Chasin, M.D., instructor in otolaryngology at Harvard; and John M. Kurkjian, M.D., assistant in otolaryngology at Harvard. C. V. Mosby Co., St. Louis. 1966. 92 pages. Price: $26.50.

This book has been written primarily for the otologic surgeon. The basic principles of the histopathology in chronic middle ear and mastoid disease are described and beautifully illustrated in photomicrographic sections of temporal bones. The surgical technique for mastoidotympanoplasty is presented in detail and illustrated in stereoscopic views as well as drawings. For the otologic surgeons there is an excellent chapter on the teaching of temporal bone surgery as used at the Massachusetts Eye and Ear Infirmary.

It is a book which deserves to be read and reread by all otologists, particularly the resident in otolaryngology.—MAXINE BENNETT, M.D.

EGG IMPLANTATION

Ciba Foundation Study Group No. 23. Edited by G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown and Co., Boston, 1966. 112 pages. Price: $3.50.

Five summaries are given of basic research pertaining to egg implantation. Each is followed by specific discussion; the whole by a general discussion by a group of 26 well-known investigators. Subjects include the endocrine sequence necessary for implantation, manner of action of intrauterine devices, neural vs. humoral control of ovarian function, delay of implantation, nutritive function of decidua, probable cytoplasmic fusion between trophoblast and maternal cells and their manner of communication, and the origin of the stimulus causing attachment of the embryo to the endometrium (maternal, embryonal, or both?). The intricacies and difficulties encountered by scientists who attempt to establish a basic understanding of such a subject are well illustrated by this little book.—H. W. MOSSMAN, Ph.D.

ESSENTIALS OF ROENTGEN DIAGNOSIS OF THE SKELETAL SYSTEM

Lester W. Paul, MD and John H. Juhl, MD, professors of Radiology, University of Wisconsin Medical School. Hoeber Medical Division, Harper & Row, 49 East 33rd St., New York, N. Y. 10016. 1967. 280 pages. Price: $12:50.

This book is an excerpt from the "Essentials of Roentgen Interpretation," 2nd edition, published in 1965 by the same authors. As stated in the preface, it consists of the section on the osseous system plus the spinal cord in response to many requests.

The reproductions of the x-rays are excellent, as in the original, since they were made from the same plates. The short discussion of the clinical findings are used to explain the x-ray changes demonstrable. It is a compact book of great value to the orthopedist and practitioner who has special interest in the skeletal system and its appendages.—SION C. ROGERS, MD

CARE OF PATIENTS WITH BOWEL AND BLADDER PROBLEMS: A NURSING GUIDE

Rehabilitation Publication No. 74. The American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minn., 55404. 33 pages. Price: $1.00

A well presented manual of bowel and bladder problems and their solutions.

Normal bladder and bowel anatomy and physiology are well covered as are the alterations due to brain and/or cord injury or disease. Programs of bladder and bowel training based on these alterations are generally well detailed and specific. However, nothing specifically was discussed about the management of bowel problems of patients with permanent nerve damage to sacral nerves, while management of bladder problems under similar circumstances is adequately covered. The need for individualized programs is emphasized.

In the opinion of the reviewer, this manual would be very helpful to doctors, nurses, patients and their families in planning, implementing and evaluating bladder and bowel training programs for persons with brain and cord damage.—JANICE McKEACHERN, RN

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COUNTY MEDICAL SOCIETIES

Presidents and secretaries of the 54 component county medical societies are listed periodically.

MEDICAL MEETINGS
POSTGRADUATE COURSES

1969 WISCONSIN

Dec. 3: "In-Depth" Teaching Program on "The Role of Exercise in Heart Disease," State Medical Society of Wisconsin and University of Wisconsin Medical School, Gymnasium Unit II of University Natatorium and SMS headquarters, Madison.

1969 NEIGHBORING STATES

Dec. 4–5: Conference on Obstetrics and Gynecology, University of Iowa Health Center, Iowa City.

Dec. 5–6: Cardiac and Respiratory Disease Conference, University of Iowa Health Center, Iowa City.

Dec. 10: Frontiers of Medicine (fifth series)—Trauma, University of Chicago, Chicago.

1969 OTHERS

Dec. 3–4: Postgraduate course on "Respiratory Failure—Acute and Long-Term Management," Cleveland Clinic Educational Foundation, Ohio.

Dec. 6–11: Annual meeting, American Academy of Dermatology, Bal Harbour, Fla.

Dec. 8–11: Sixth Annual New Orleans Course on Pulmonary Function in Health and Disease, American Thoracic Society with others, Louisiana State University School of Medicine Auditorium, New Orleans.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium). Hahnemann Medical College and Hospital, Philadelphia, Pa.

Dec. 10–11: Postgraduate course on "Concepts in Diagnosis and Management of Diseases of Vitreous, Retina and Choroid," Cleveland Clinic Educational Foundation, Ohio.

Dec. 20: Departure date for 63 days aboard SS President Cleveland, from San Francisco for Ninth Educational Cruise for TIPS (Trans-International Psychosomatic Seminars), to South Pacific.

1969 AMA

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

Jan. 22: "In-Depth" Teaching Program on "The Abused Child," State Medical Society of Wisconsin and University of Wisconsin Medical School, University Hospitals and SMS headquarters, Madison.

Feb. 19: "In-Depth" Teaching Program on "Osteoporosis—Newer Diagnostic Methods and Evaluation of Therapy," State Medical Society of Wisconsin and University of Wisconsin Medical School, University Hospitals and SMS headquarters, Madison.

Mar. 11: Conference on the Provision of Occupational Health Services to the Small Industrial Plant, Racine Motor Lodge, Racine (sponsored by the Committee on Occupational Health of the State Medical Society of Wisconsin).

Mar. 12–14: Infectious Disease Conference, University Extension, Department of Postgraduate Medical Education, University of Wisconsin, Wisconsin Center, Madison.

Mar. 18: "In-Depth" Teaching Program on "Psychotherapeutic Drugs," State Medical Society of Wisconsin and University of Wisconsin Medical School, University Hospitals and SMS headquarters, Madison.

Mar. 18: Symposium on Farm Accidents, Valhalla Hall, Wisconsin State University at La Crosse (sponsored by Committee on Occupational Health of the State Medical Society of Wisconsin).

Apr. 1–2: Fifth Postgraduate Teaching Days in Sports Medicine, University Extension, Department of Postgraduate Medical Education, University of Wisconsin, Wisconsin Center, Madison.

Apr. 16: Perinatal Care Conference, University Extension, Department of Postgraduate Medical Education, University of Wisconsin, Wisconsin Center, Madison.

Apr. 24–25: Wisconsin Urological Society meeting, Wisconsin Center, Madison.

Apr. 25–26: Ophthalmic–Pathology Society meeting, Wisconsin Center, Madison.

May 11–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 NEIGHBORING STATES

Jan. 14: Frontiers of Medicine (fifth series)—Recent Progress in Human Genetics, University of Chicago, Chicago.

Feb. 11: Frontiers of Medicine (fifth series)—Abnormal Uterine Bleeding and Pain, University of Chicago, Chicago.

Feb. 16–18: Sectional meeting, American College of Surgeons, St. Paul Hilton, St. Paul, Minn.

Mar. 1–4: Midwest Clinical Conference of the Chicago Medical Society, The Sherman House, Chicago.

Mar. 11: Frontiers of Medicine (fifth series)—Gout and Purine Metabolism, University of Chicago, Chicago.

Mar. 16–20: Clinical Problems in Internal Medicine, American College of Physicians, Cleveland, Ohio.

Mar. 23–26: Neurology and the Internist, American College of Physicians, Rochester, Minn.

Mar. 30–Apr. 3: Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, American College of Physicians, Ann Arbor, Mich.

Apr. 8: Frontiers of Medicine (fifth series)—Therapy of Leukemia and Lymphoma, University of Chicago, Chicago.

Apr. 13–16: American Industrial Health Conference, Palmer House, Chicago, Ill.

May 13: Frontiers of Medicine (fifth series)—Neurological Aspects of Systemic Disease, University of Chicago, Chicago.

June 8–12: Internal Medicine, 1970—Old Principles, New Practice, American College of Physicians, Iowa City, Iowa.

June 15–17: Blood Transfusion Therapy and Related Immunology, American College of Physicians, East Lansing, Mich.

Oct. 5–9: 53rd Annual Meeting, American Dietetic Association, Detroit, Mich.

1970 OTHERS

Jan. 2–6: PG course on "Function and Dysfunction of the Gastrointestinal Tract," University of Miami School of Medicine, at The Americana Hotel, Bal Harbour, Fla.

Jan. 4–17: Pacific Cancer Conference, American Cancer Society, Hawaii Division, Honolulu, Hawaii.

Jan. 8–11: Seventh Annual Postgraduate Seminar on "Advances in Respiratory Care and Physiology," University of Miami School of Medicine, at Eden Roc Hotel, Miami Beach, Fla.

Jan. 9: Sectional Meeting, American College of Surgeons, Americana Hotel, San Juan, Puerto Rico.

Jan. 14–15: PG course on "Selected Problems in General Surgery and Vascular Surgery," Cleveland Clinic Educational Foundation, Ohio.

Jan. 16–17: Sectional Meeting, American College of Surgeons, Mancuto–Sheraton Hotel, Caracas, Venezuela.

Jan. 18–24: Sixteenth Annual General Practice Review, University of Colorado School of Medicine, Denver.

Jan. 21–23: Sectional Meeting, American College of Surgeons, El Panama Hotel, Panama City, Panama.

Jan. 23–25: Eighth Clinical Conference in Pediatric Anesthesiology, Childrens Hospital of Los Angeles, Calif.

Feb. 1–4: Theodor Billroth Course in Surgical Anatomy, Loma Linda University School of Medicine, Loma Linda, Calif.

Feb. 2–4: Sectional Meeting, American College of Surgeons, Portland Hotel, Portland, Ore.

Feb. 2–6: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Feb. 12–14: Second National Conference and Exposition on Electronics in Medicine, Electronics/Management Center of McGraw–Hill Publications Company, Fairmont Hotel, San Francisco, Calif.

Feb. 14–15: PG Course on Allergy, Immunology, and Related Fields at 26th Annual Meeting of American Academy of Allergy, Jung Hotel, New Orleans, La.

Feb. 14–21: Fourth Annual Alumni/Faculty Retreat, Wisconsin Medical Alumni Association, Puerto Vallarte, Mexico.

Feb. 17–20: PG Course on Surgery of the Hand, University of Colorado School of Medicine, Humphreys Postgraduate Center, Denver, Colo.

Feb. 25–Mar. 1: Nineteenth Annual Scientific Session, American College of Cardiology, Rivergate Center, New Orleans, La.

Mar. 9–27: Course for physicians in Occupational and Environmental Medicine, New York University Post-Graduate Medical School, New York.

Mar. 16–18: Sectional Meeting, American College of Surgeons, Sheraton Park Hotel, Washington, D.C. (Combined annual meeting for surgeons and nurses).

Apr. 6–10: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Apr. 11–12: Fifteenth Annual PG Assembly, The Los Angeles County Society of Anesthesiologists, Los Angeles Hilton Hotel, Calif.

Apr. 15–17: Course on "The Management and Care of Respiratory Insufficiency," U of Colo School of Medicine, Denver.

Apr. 26–30: First International Congress on Group Medicine, Winnipeg, Manitoba, Canada.

May 7–9: Annual Meeting, American College of Sports Medicine, Albuquerque, N.M. (Exec. Secy.: Mr. Donald E. Herrmann, 1440 Monroe St., Madison, Wis. 53706).

May 22–29: Tenth International Cancer Congress, Houston, Tex.

July 6–9: Course on Ophthalmology, U of Colo School of Medicine, Estes Park.

July 19–22: Course on Pediatrics, U of Colo School of Medicine, Aspen.

July 27–31: Course on Internal Medicine, U of Colo School of Medicine, Estes Park.

Aug. 3–7: Sixteenth Annual General Practice Review, U of Colo School of Medicine, Denver.

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

Oct. 5–9: Course on High Risk Infant Care, U of Colo School of Medicine, Denver.

Dec. 6–11: Second International Clean Air Congress, Washington, D. C.

1970 AMA

Apr. 9–10: Rural Health Conference, American Medical Association, Pfister Hotel and Tower, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1971 NEIGHBORING STATES

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the **Journal of the American Medical Association.**

Gastrointestinal Tract—Miami Beach

The American College of Physicians will present a course on "Function and Dysfunction of the Gastrointestinal Tract," in cooperation with the University of Miami School of Medicine, Jan. 2–6, at The Americana Hotel, Bal Harbour, Fla.

The five-day course will emphasize both the basic and clinical aspects of function and dysfunction of most of the major organ systems of the gastrointestinal tract. Recent progress and current status in gastrin, immunoglobulins and gastrointestinal disease, lipid assimilation, bilirubin metabolism and cholestasis are included topics.

Fees: ACP members, $60; nonmembers, $100; residents and research fellows, $60. Registration, information, and application to: Edward C. Rosenow, Jr., MD, FACP, Executive Director, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Pacific Cancer Conference—Hawaii

The American Cancer Society, Hawaii Division, is sponsoring a Pacific Cancer Conference in Honolulu, Hawaii, followed by a vacation on the Islands of Kauai and Maui, Jan. 4–17.

Cost: $479.31 per person plus air fare (air fare from Chicago to Hawaii is $354.77). Reservations to: Professional Seminar Consultants, Inc., 3194 Lawson Blvd., Oceanside, N. Y. 11572.

Cardiovascular Specialists to New Orleans

The American College of Cardiology, the national medical society for specialists and research scientists in cardiovascular diseases, will hold its 19th Annual Scientific Session Feb. 25–March 1, 1970 in New Orleans, La. All sessions will be held at The Rivergate Center.

Major scientific symposia will include such topics as surgery for complications of myocardial infarctions, cardiac valve substitution and pulmonary circulation. A new feature at the meeting this year will be a core curriculum in clinical cardiology and a self-assessment classroom.

A special group of panel discussions, called Controversies in Cardiology, will feature discussions by authorities on op-

posing sides of current issues. Topics will include prevention of atherosclerosis, homografts vs. prosthetic heart valves, alcoholic heart disease and surgery for coronary disease.

Doctors attending the meeting will also have a choice of 20 evening Fireside Conferences, 21 Luncheon panels, Clinical Conversations with Master Teachers, and a Round of Clinics and Demonstrations being arranged with hospitals and medical schools in the New Orleans area, according to B. L. Martz, M.D., Indianapolis, Ind., College President.

George E. Burch, M.D. and Allan M. Goldman, M.D., both of New Orleans, La., are General Co-Chairmen of the Session. Dr. Burch is Past President of the College and Professor and Chairman of the Department of Medicine at Tulane University Medical School. Dr. Goldman is Professor of Clinical Medicine at the medical school.

INFO: William D. Nelligan, Executive Director, 9650 Rockville Pike, Bethesda, Md. 20014.

Electronics in Medicine—San Francisco

Dr. Roger O. Egeberg, assistant secretary of the Department of HEW, will address medical and engineering specialists from around the world at the Second National Conference and Exposition on Electronics in Medicine at the Fairmont Hotel in San Francisco, Calif., Feb. 12–14.

The meeting is sponsored by the Electronics/Management Center of McGraw–Hill Publications Company, in association with five McGraw–Hill publications: ELECTRONICS, MEDICAL WORLD NEWS, MODERN HOSPITAL, POSTGRADUATE MEDICINE, and SCIENTIFIC RESEARCH.

The conference will present specific, seminar-style discussions of problems and developments in medical engineering, instrumentation, and data handling.

Further information: James P. Roscow (212) 971–6757.

Conference on Rural Health—Milwaukee

The 23rd National Conference on Rural Health will be held Apr. 9–10 (and not 10–11 as previously reported) at the Pfister Hotel and Tower in Milwaukee.

Sponsored by the American Medical Association, the conference has as its theme, "Let's Put *You* in Comm-u-nity Health." There will be a number of Wisconsin physicians participating in the program which will be announced later.

Surgical Anatomy—California

The Theodor Billroth Course in Surgical Anatomy will be conducted by the Department of Anatomy of the Loma Linda University School of Medicine, Feb. 1–4, Loma Linda, Calif.

Fee: $150. Reservations by Jan. 5 to: Dept. of Anatomy, School of Medicine, Loma Linda University, Loma Linda, Calif. 92354.

Spring 1970
Occupational Health Conferences
Racine and La Crosse

The State Medical Society of Wisconsin, through its Committee on Occupational Health of the Commission on Health Information, will sponsor two scientific programs in the spring of 1970.

On Mar. 11 a Conference on the Provision of Occupational Health Services to the Small Industrial Plant will be held at the Racine Motor Lodge in Racine. Dr. Louis Olsman of Kenosha, a member of the Committee, will have charge of this program.

On Mar. 18 a Symposium on Farm Accidents will be held at Valhalla Hall on the Wisconsin State University at La Crosse campus in La Crosse. Dr. Allen G. Brailey, Jr. of La Crosse, also a member of the Committee, will conduct this program.

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REFERENCES:
1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

Seminar—Miami and Florida Universities

The Seventh Annual Postgraduate Seminar on "Advances in Respiratory Care and Physiology," sponsored by the University of Miami School of Mediicne and the University of Florida College of Medicine, will be conducted Jan. 8–11 at the Eden Roc Hotel in Miami Beach, Fla.

Registration fee: $100; residents only, $45. Registration to: Postgraduate Seminar in Anesthesiology, Suite 601, Professional Arts Center, 1150 NW 14th Street, Miami, Fla. 33136.

Pediatric Anesthesiology—Los Angeles

The Childrens Hospital of Los Angeles will present the Eighth Clinical Conference in Pediatric Anesthesiology Jan. 23–25 in the Lecture Hall of the hospital.

Registration fee—$75; application to: Wayne Herbert, MD, Program Director, Childrens Hospital of Los Angeles, 4650 Sunset Blvd., Los Angeles, Calif. 90054.

Allergy Course in New Orleans

The American Academy of Allergy will present a two-day postgraduate course in connection with its 26th annual meeting, Feb. 14–18, at the Jung Hotel in New Orleans, Louisiana.

The postgraduate program offers subjects of timely interest in allergy, immunology and related fields.

The Annual Meeting scientific sessions will convene Monday, February 16, ending Wednesday, February 18. The program for three days will highlight presentations of new research in allergy and related fields.

Both meetings are open to all physicians and others interested in attending.

Details of the program can be obtained by writing to the American Academy of Allergy Executive Office, 756 North Milwaukee Street, Milwaukee, Wis. 53202.

Industrial Health Conference—Chicago

The 1970 American Industrial Health Conference will be held Apr. 13–16 in Chicago, Ill., with headquarters at the Palmer House, it has been announced by the Industrial Medical Association and the American Association of Industrial Nurses. This medical–nursing Conference, which is comprised of the annual meetings of the two sponsoring organizations, will bring together approximately 2,500 persons including industrial physicians, industrial nurses, safety engineers, industrial hygienists, public health officials, academicians and management representatives.

The scientific program, in which many of the nation's experts in the field of occupational health will participate, will be augmented by both scientific and technical exhibits. Postgraduate seminars and workshops in selected areas of industrial medical practice also will be presented.

Registration is open to anyone having an interest in the health of the working population. The registration fee is $10.00. For copies of the preliminary program and registration forms, write Howard N. Schultz, Executive Director, American Industrial Health Conference, 55 East Washington St., Chicago, Ill. 60602.

International Cancer Congress—Texas

More than 1400 cancer specialists of the world will participate in the scientific program of the Tenth International Congress, May 22–29 in Houston, Tex., representing leading cancer and research institutions from many of the 70 nations which have membership in the International Union Against Cancer.

Further information: Office of the Secretariat, Tenth International Cancer Congress, P.O. Box 20465, Astrodome Station, Houston, Tex. 77025.

A TEACHING SERVICE OF THE CES FOUNDATION, STATE MEDICAL SOCIETY OF WISCONSIN

1969-1970
"In-Depth" Teaching Programs

PROVIDED BY UNIVERSITY OF WISCONSIN MEDICAL SCHOOL FACULTY

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SCHEDULE: 10:00 a.m.—University Hospitals for patient discussions, Room 300, Third Floor (except for Dec. 3 program which will be held at Gymnasium Unit II of the University Natatorium); 12:30 p.m.—Lunch at State Medical Society headquarters (included in fee); 1:15–4:00 p.m.—Program at SMS. CREDIT: Five hours AAGP credit. FEE: $5.00 per meeting, $20.00 for all four. ADVANCE REGISTRATION: David C. Reynolds, State Medical Society, Box 1109, Madison, Wis. 53701.

WED. DEC .3 1969

THE ROLE OF EXERCISE IN HEART DISEASE

Faculty:
NEVILLE BITTAR, M.D.; KARL G. STOEDEFALKE, Ph.D.; BRUNO BALKE, M.D.; JOHN P. NAUGHTON, M.D. (Chicago); CHARLES W. CRUMPTON, M.D.; THOMAS J. REEVES, M.D. (Birmingham); GEORGE G. ROWE, M.D.

Topics:
"Methodology of Exercise and Stress Testing Demonstrations" . . . "Epidemiology of Heart Disease in Relation to Physical Activity" . . . "Cardiac Function During Exercise" . . . "Exercise Prescription" . . . "Criteria for Selection of Patients for an Exercise Program" . . . "Stress Testing: Role in Cardiac Diagnosis" . . . "Rehabilitation of the Cardiac Patient" . . . "Risks and Rewards of Exercise Therapy"

Note: Program at University Natatorium, 2000 Observatory Drive.

THURS. JAN. 22 1970

THE ABUSED CHILD

Faculty:
CHARLES C. LOBECK, M.D.; JACK C. WESTMAN, M.D.; RICHARD WESENBERG, M.D.; MARYGOLD S. MELLI, LL.B.; MR. MAX WALD

Topics:
"Presentation of Patients" . . . "Extent of the Problem in Wisconsin and the Nation" . . . "The Law and the Abused Child" . . . "Clinical Diagnosis of Child Abuse" . . . "Why Is a Child Abused"

THURS. FEB. 19 1970

OSTEOPOROSIS—NEWER DIAGNOSTIC METHODS AND EVALUATION OF THERAPY

Faculty:
MARK N. MUELLER, M.D.; JOHN R. CAMERON, Ph.D.; JOHN JURIST, Ph.D.; RICHARD MAZESS, Ph.D.; MR. GARY FULLERTON

Topics:
"Dimensions of the Problem of Osteoporosis in the U.S." . . . "Physical Methods in Assessing Bone Mineral Content" . . . "Resonant Frequency of Bone as a Measure of the Quality of the Organic Component of Bone" . . . "Skin Thickness and Transparency: Correlation with Presence of Osteoporosis and Its Severity" . . . "Osteoporosis in Rheumatoid Arthritis—Relationship to Duration and Severity of Disease and Therapy of Arthritis" . . . "Evaluation of Therapy of Osteoporosis"

WED. MAR. 18 1970

PSYCHOTHERAPEUTIC DRUGS

Faculty:
BEN H. GLOVER, JR., M.D.; JOSEPH M. BENFORADO, M.D.; CARL H. FELLNER, M.D.; JOSEPH GREEN, M.D.; JOSEPH G. KEPECS, M.D.; ARNOLD LUDWIG, M.D.; WILLIAM McKINNEY, M.D.; GILBERT TYBRING, M.D.

Topics:
"Clinical Use of New Psychotherapeutic Drugs" . . . "Therapeutic Drug Effects (Clinical Presentation)" . . . "Treatment without Drugs" . . . "Experience with Experimental Drugs" . . . "Alcoholism and Drug Therapy" . . . "Children and Psychotherapeutic Drugs" . . . "Basic Pharmacology and Toxicology of Psychotherapeutic Drugs"

PRESIDENT'S PAGE

Gunnar Gundersen, M.D.

THE STATE MEDICAL SOCIETY OF WISCONSIN appropriately honors Gunnar Gundersen, M.D. with this Festschrift issue, as he indeed is one of our most illustrious members.

While most of us associate Doctor Gundersen with the presidency of the American Medical Association, years of devoted professional and public service have preceded and followed his term as president, the highest honor within the gift of physicians to a colleague.

With equal distinction he served his state as a member of the Board of Regents of the University of Wisconsin and as president of the former State Board of Health; the world health community as a member of the Council of the World Medical Association; the State Medical Society of Wisconsin as its president, speaker of the House of Delegates, a member of the founding board of Wisconsin Blue Shield (WPS), and a member of numerous Society commissions and committees; the American Medical Association as its president, chairman of the Board of Trustees, delegate to the House of Delegates, chairman of the American Medical Political Action Committee (AMPAC), and as the first chairman of the Joint Commission on Accreditation of Hospitals.

A member of a family of eminent physicians and of the widely known clinic that bears his family name, Dr. Gunnar Gundersen remains first and foremost a physician who has practiced his specialty of surgery in La Crosse, Wisconsin, since 1922 when he became associated with his Norwegian-born father, Adolf.

Through the years, Doctor Gundersen has developed that rare quality of having both professional and administrative expertise.

In the depression years, Doctor Gundersen remained forward-looking and had the great fortitude to promote expansion of the La Crosse Lutheran Hospital which his father co-founded in 1899. He continues to be aggressive in the building programs of the hospital and clinic. In 1961, when the original hospital structure was destroyed by fire, Doctor Gundersen led the campaign to rebuild.

Doctor Gundersen remains active at all levels of medicine and lends a steadying objectivity to all deliberations—scientific and social. In administrative affairs he has shown unique astuteness and judgment. These attributes are broadly reflected in the Adolf Gundersen Medical Foundation which Dr. Gunnar helped establish in 1944 with other members of his family.

His many friends and colleagues know him for his calm, gracious dignity and for his clear eye, good judgment, and tact. He stands erect and his contributions to humanity praise him far better than another man's words.

The State Medical Society extends to Dr. Gunnar Gundersen its heartfelt appreciation.

Robert E. Callan M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

In Tribute

THE CAREER OF Dr. Gunnar Gundersen, whom this issue honors, has continued with distinction through dramatically changed periods of medical history. In the 72 years of his life, the practice of medicine has come from a horse-and-buggy configuration to that of a life-preserving and life-extending science using techniques undreamed of at the turn of the century. Through all, Dr. Gundersen has exemplified the high ideals of the citizen–doctor whose concern for human welfare could focus on a local practice as well as extend to the broad horizon of international medical organizations.

A native of La Crosse, Dr. Gundersen interned in Lutheran Hospital in that city and established his first practice there. But his dedication to public service, his vast energies and his eminent qualifications soon involved him not only in state medical organizations, but carried him also to a position of high responsibility as a Regent of the University of Wisconsin.

He served as a member of the founding Board of Directors of Wisconsin Blue Shield, and as a member and ultimately President of the Wisconsin State Board of Health. He climaxed his state career as President of the State Medical Society in 1941–1942.

On the national scene, Dr. Gundersen was one of the six representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals and served as Commission chairman during its two formative years. He was elected to the Board of Trustees of the AMA and served two terms as its chairman. During this period, he represented the AMA on the Council of the World Medical Association.

And finally, in 1957, he was accorded the highest honor a physician can receive from his colleagues: he was elected President of the American Medical Association.

Although Dr. Gundersen has seen many worlds in his lifetime and practiced radically altered kinds of medicine, his constancy of character and devotion to the delivery of better health care remained steady amidst the turmoil and ferment of change. It is to these enduring qualities of a great doctor and a great man that we pay tribute now—not only to give honor to the man, but to remind ourselves of the magnitude of the human spirit and to the heights to which it can rise.

As we salute Gunnar Gundersen, M.D. we acknowledge a superb career, representative of the lofty ideals to which we may all aspire.

—D. N. G.

Of Many Facets

THE MORE PRECIOUS the diamond, the more facets it carries.

Dr. Gunnar Gundersen is a man of many facets —and hardly more can be said about him.

I have known this fine physician, his gracious wife, and his family for many years.

This issue of the *Wisconsin Medical Journal* simply could not "be put to bed" without some acknowledgment of his many contributions to the organizational strength of the State Medical Society of Wisconsin.

Indeed, Doctor Gunnar is a man of many facets. Wisconsin medicine is grateful for his work . . . the staff shares that appreciation.—C.H.C.

The Need Is Now

THE FINANCIAL CRISIS in medical education has special impact for Wisconsin physicians because of the situation of Marquette Medical School. This fine, established institution has been separated from the University of Marquette and unless funds are found to support its operation, it may have to close its doors.

In the face of this possibility, experts estimate that the United States will require the services of 400,000 physicians by 1975, one-third more than now practice in this country. At a time when medical schools should be increasing their enrollment capacity, when more and more medical schools should be opened, the existing institutions are faced with inadequate financial support.

Even schools with large endowments are often handicapped because their funds are frequently earmarked for special purposes.

Physicians who are concerned with this problem affecting the future of their profession—and all of us should be concerned—can help support institutions of medical education by sending a contribution to the State Medical Society's CES Foundation for the AMA's Education and Research Foundation. These contributions can be earmarked for specific schools, such as Marquette, or can be included in the general fund. The latter is unrestricted and flexible, distributed evenly to all medical schools, permitting the deans to use the money to solve the financial problems of their institutions as they see fit.

As the AMA–ERF points out, the future of American medicine depends on the concern and generosity of practicing physicians. Contributions are urgently needed at the present time. It is to be hoped that those of us who have benefited by the generosity of others will return that generosity now in this time of financial crisis.—D.N.G.

Positive Perspection

WHEN I CAME to the staff of the State Medical Society in June of 1947, my very first day "on the job" was at the Annual Meeting of the American Medical Association in Atlantic City. It was there I met Gunnar Gundersen, MD. He stepped aside from the hubbub of the meeting not only for greetings but also to provide a bit of philosophy which I paraphrase: "Medicine's great heritage is a positive attitude. We must keep it that way."

It is a perspective he always works at. When traveling to a county society meeting in Ashland, there is always time to see some little known historical marker on a side road. A trip to the eastern part of the state is not complete without an on-site inspection of a bog at the Rapids or a drumlin at Eagle. At home, a discussion of world health is never fully satisfied without an appraisal of the geraniums in Mrs. Gundersen's greenhouse just off the kitchen. For dessert, amid political talk, there is a cliff-hanger of a jeep ride to explore the practical applications of coulee conservation in Glen Cameron.

The perspective is always positive. The man, total. The physician, complete. The friend, good . . . satisfying. Thank you, Gunnar Gundersen, MD.

—E.R.T.

Time for Action

THE INCREDIBLE INCREASE in the cost of malpractice insurance continues to shock and exasperate practicing physicians. In the State of California, according to a recent news report, rates were doubled on October First. Premiums have been increased 100% in Vermont, 75% in Ohio, 100% in Michigan, and 250% in the Philadelphia area of Pennsylvania. In Wisconsin, the rate of increase has been proportionately rapid.

Does this mean that physicians are practicing medicine more carelessly than ever before? Are more people suffering compensable loss as a result of the negligence, ignorance or indifference of their physicians?

While it is possible that the greater number of persons receiving medical care today are experiencing a commensurate number of "bad results" than were experienced two decades ago, the cost of malpractice insurance has risen disproportionately. The real reason for the explosion in insurance rates seems to be the greater number of nuisance cases that have been instituted and pursued to a settlement of some kind. The willingness of courts to assume that the very experience of a bad result implies negligence makes it attractive for a disgruntled patient and an unprincipled lawyer to work a potentially rich source of profit.

Throughout the country, courts have liberalized rules of evidence in trying malpractice suits. The statute of limitation has been extended to run from the time of discovery of the alleged malpractice.

The application of the doctrine of *res ipsa loquitur* replaces expert opinion with a socalled common sense conclusion. And a willingness on the part of court and jury to "sock it" to the big, impersonal, wealthy insurance company and the rich doctor has resulted in awards of fantastic sums.

The losses by insurance carriers have become so great that some have withdrawn altogether from the field of malpractice insurance. Others stay in by insuring doctors in relatively "safe" practices; they won't insure, for example, surgical specialists. The insurance companies who remain in the business understandably have increased their premiums in order to cover their losses.

As a result of the patient with an unjustified claim and his lawyer attempting to take advantage of the exposed and vulnerable physician, the price of medical care for all patients must be increased. The cost of insurance is one of the factors that establish the ultimate price of medical care delivered to the patient, and the apparent willingness of the courts to sympathize with an unhappy patient at the expense of his doctor is clearly driving the price upward.

The vulnerability of the doctor to a nuisance malpractice suit makes any provident physician careful about what kind of patient relationships he establishes and with whom. It is no accident that the newcomer in the community and the transient may find it difficult to obtain treatment except in a hospital emergency room. The physician who undertakes to treat a stranger is literally putting his career on the line.

No doctor can defend actual negligence, and no doctor should shrink from testifying on behalf of a patient who has been a victim of deplorable medical practice. But at the same time, no doctor should be held responsible for the unavoidable consequences of the diseases to which the flesh is heir—as long as the care he delivered was reasonable, efficient, knowledgeable and in conformance with the standards of the community.

The problem is not one that can be solved by the medical profession and the insurance industry alone. It requires an awareness on the part of the community as to how much nuisance malpractice suits are costing, individually as well as collectively. It requires cooperation on the part of the Bar Associations, to establish standards of ethics for lawyers who indulge freely in the institution of malpractice suits. It is no accident that there are relatively few such suits in Canada and Great Britain, where it is illegal for a lawyer to accept a case on a contingency basis.

There are several avenues that organized medicine can follow to reach a solution to the problem of unjustified malpractice suits:

—Conference with the Wisconsin Bar Association to establish standards of ethics for lawyers engaging in cases of alleged malpractice;

—Investigation of the possibility of establishment of a quasi-judicial screening commission to disqualify malpractice suits that are filed without any merit whatsoever;

—Investigation of the use of an arbitration agency that would hear claims and settle them out of court without the expense of lawyers and court fees and without exposing doctors to the caprice of bleeding heart juries. If such an agency were established, doctors could request their patients to agree to accept such arbitration before rendering treatment;

—Establishment of a corps of medical experts whose opinion would be available to doctors enmeshed in an unjustified malpractice suit;

—Institution of a program of public education to make the community aware of how much the vicious greed of some patients and their lawyers is costing everyone who ever has need of medical attention;

—Greater effort on the part of organized medicine to persuade legislators to curb the free-wheeling excesses of courts in making doctors pay through the nose for the pathetic plight of unfortunate patients.

In the meantime, doctors must continue to "run scared," to exercise every precaution to avoid the possibility of a legitimate malpractice suit: knowing the patient, the maintenance of complete records, use of recognized procedures, close supervision of subordinates, and use of all the proven methods of self-protection against the most remote contingencies. With juries eager to award damages for misfortune regardless of cause, every doctor owes it to himself and his family to practice medicine as though he were in constant danger.

In years gone by, a sure road to affluence was to enter medical school, study hard, risk your capital to establish a practice, work long hours, and devote yourself to the care of your patients. Nowadays, another sure road to affluence is to find such a person—and sue him.

Somehow, the threat of nuisance suits for malpractice must be limited. No profession can continue forever to serve the public under that kind of hazard.

—D.N.G.

DIABETES DETECTION

Employees of the White Memorial Medical Center in Los Angeles were screened for diabetes during a one-day Why Wait? drive on June 2. The voluntary program tested 289 employees, about 30 per cent of the staff.

Nineteen positives were identified at the initial screening, which consisted of a capillary blood sugar test two hours after ingestion of a carbohydrate challenge. Screenees with positive readings (130 + mg%) were referred to the employee health department, where they were given a three-hour GTT. Screening was conducted by the inservice education and employee health departments.—*Disease Detection Newsletter, Vol. 2, No. 3 (August 1969)* □

GUNNAR GUNDERSEN

Festschrift

WISCONSIN MEDICAL JOURNAL
November 1969

". . . A tower of strength to his medical profession and to the public it serves, state and nationally."

A Man Honored

Excerpts from a feature story written by James O. Holmlund in the *La Crosse Tribune*, March 1, 1958 issue, at the time Dr. Gunnar Gundersen was honored by the La Crosse County Chamber of Commerce.

A FAVORITE SPOT for contemplation in the Gundersen home is the comfortable area near the oil painting of Dr. Gunnar's father, Adolf, who came to La Crosse in 1891 and died in 1938 after founding the La Crosse Lutheran Hospital and Gundersen Clinic.

"How does Dr. Gundersen, 60, one of six sons who became medical men, look at the job starting in June, when he takes over the reins of AMA?

"The big, one-year job ahead is a pinnacle of recognition by his fellow physicians, he feels, but the occasion finds him not liking to make speeches and without a fund of stories.

"He said, 'I can't tell stories.' He depends for his good humor on personal experiences of life.

"He likens his forthcoming assignment to 'the lift' he got when he was president of the Wisconsin State Medical Society in 1940–41. He said the state office had the 'high respect' of other doctors and 'perhaps the same' feeling exists for the national office.

"Dr. Gundersen, rather a reserved, modest individual, although he thinks and speaks analytically and critically, is a real champion for free enterprise and the American way.

"He brings . . . considerable experience in AMA doings and the ability to write his own speeches.

"Dr. Gundersen, exhibiting additional modesty, looks on his getting the AMA presidency as 'an accident, being at the right place at the right time.' But, the record shows, it has been his long interest in 'organized medicine' that led him to this high reward.

"How did Dr. Gundersen—a 1920 graduate from the College of Physicians and Surgeons, Columbia University, New York—become interested in organized medicine? It started, he recalled, in about 1930 when a State Medical Society committee conducted a study of socio-economic problems of the medical profession. He served on the committee.

"His interest in the broad aspects have taken the doctor and his wife to many parts of America, Europe and Russia . . . they attended the World Medical Association meeting in Istanbul, Turkey . . . The Scandinavian countries have been well traveled by the pair, having family members living in Norway.

"Dr. Gundersen was the third born of a family of seven boys and one girl. He was born April 6, 1897, to Dr. Adolf and Mrs. (Helga) Gundersen in the family's home at 1231 Ferry St. [La Crosse, Wisconsin]. Dr. Christian Christensen, a partner of his father was present at the birth.

"He attended what was then known as the 3rd Ward School, now Lincoln School, but was not making progress in his upper grade years.

"The parents sent him to a private prep school in Oslo, Norway, for three years. Two brothers, Sigurd, for three years, and Alf, for one year, attended the same school.

"'It was rough at first,' Dr. Gundersen recalled of being away from family and friends. But later, after making contact with Norwegian life, he made many friends, got to know Norwegian better than English and finished the gymnasium, or high school, course at 18.

"Through the years his mother, active church worker and student of Ibsen, instilled in him and five of the six other brothers, a love for medicine. The conditioning worked. The father [a pioneer physician] at the time had his office at 3rd and Pearl streets [now known as the original Gundersen Clinic].

"At 18, Gunnar entered the University of Wisconsin, where he received a bachelor of science degree in 1917. He had no time for extra-curricular activities.

A FAVORITE MODE OF TRANSPORTATION on the Gundersens' 120-acre farm within one mile of the La Crosse city limits is this jeep which Doctor Gunnar reportedly "drives like a burro, makes it stand on its nose, rear on its hind wheels and practically ride on its side." Only last month, Doctor Gundersen was in Wyoming on a hunting expedition, with a jeep as his companion. (Photo courtesy of the Minneapolis Sunday Tribune, Sept. 29, 1957 issue)

"He was just as busy in medicine at Columbia, where he received his M.D. in 1920. While at the New York City school he was a member of the Student Army Training Corps program, although never on active duty.

"Dr. Gundersen was licensed to practice the year of graduation, interning at La Crosse Lutheran Hospital. His medical practice has been continuous in La Crosse since.

"In 1927, the Gundersen Clinic was founded by the father, Dr. Adolf, and three sons, Dr. Gunnar, Dr. Sigurd and Dr. Alf Gundersen. There were six physicians at the time at the South Avenue location. Today there are 26. [And now, in 1969, there are 70.]

"Dr. and Mrs. Gunnar Gundersen are the parents of three children. Mary (Mrs. Fredrik Bugge) lives in Oslo, Norway, although a citizen of the United States; Dr. Gunnar A., a radiologist at the local clinic; and Capt. Cameron Gundersen, an internist and currently on duty with the United States Air Force. [The daughter still resides in Norway; the two sons are associated with their father at the Gundersen Clinic.]

"Twelve years ago the Gundersens moved to Glen Cameron, a property previously owned by Cameron Baldwin [Mrs. Gundersen's father] since 1913 and reforested by Dr. Gundersen. In fact, forestry is a handed-down trait and love from Dr. Gunnar's father.

"Dr. Gunnar's interest in trees began more than 30 years ago. He helped plant seedlings in the now Hoeth Forest in northern La Crosse County.

"He and his brother, Dr. Sigurd, began planting trees about the same time on some 200 acres of cutover land in Sawyear County. A cottage is shared in the same north country area.

"The 20-year tree planting effort at Glen Cameron—pine, spruce, other conifers and hard sugar maples—amounts to about 25,000 specimens today. All have been planted by hand and most of them by Dr. Gundersen.

"'I find it very rewarding,' Dr. Gundersen commented. 'Like getting into a different world.' His brothers, too, have taken to nature, including gardening, farming and dogs.

"He is a reader of medical volumes and historical and biographical selections.

"Dr. Gundersen in 1946, together with the late Reuben Trane, headed the building fund committee for La Crosse Home for Children; is a former director of the local Red Cross chapter; and in 1939 was chairman of the arrangements committee for the reception of Norwegian royalty visiting La Crosse."

Honored by La Crosse Community

The respect and admiration with which Dr. Gunnar Gundersen is held in his own community of La Crosse was appropriately recognized in the spring of 1958—just before he took over the presidency of the American Medical Association—when the La Crosse County Chamber of Commerce honored him at a testimonial event.

The distinguished physician and surgeon was given the Chamber's 12th President's Award—a walnut engraved plaque—citing him for "loyal, untiring service for the betterment of many, and outstanding personal civic service to the community."

In receiving the honor Doctor Gundersen remarked, "I can't help but feel humble and modest in a situation like this. I do so very much appreciate this and you are actually honoring the AMA and not me." He paid thanks to his colleagues at the clinic and hospital for their "sympathetic understanding" during his "absenteeism." He also thanked Wisconsin physicians for their "loyalty" expressed to him in the past and showed appreciation to Minnesota and Iowa physicians.

Doctor Gundersen is shown above, second from right, receiving the award from A. C. Trimble, left, Chamber president. Next to Mr. Trimble is Dr. David B. Allman, Atlantic City, N. J., AMA president, and on the right is Bernard Decheine, president-elect of the Chamber. (La Crosse Tribune Photo)

GUNNAR GUNDERSEN, M.D.

I have had the privilege of knowing Doctor Gunnar Gundersen since returning to Wisconsin in 1946 after my army service and opening my private practice in La Crosse.

I have served on many medical committees with Doctor Gunnar during the past 23 years and had the honor while president of the La Crosse County Medical Society to present him with a commemorative plaque recognizing his accomplishments on both the County and State levels prior to his becoming president of the American Medical Association.

In our County he stood tall and his advice has often been sought and followed.

Doctor Gunnar Gundersen is to be congratulated for his contributions to Medicine, locally, state-wide and nationally.

John J. Satory, M.D.
La Crosse

RESOLUTION

WHEREAS, The presidency of the American Medical Association is the highest honor within the gift of physicians to a colleague and is traditionally bestowed upon a member whose career has been marked by long and devoted professional and public service; and

WHEREAS, Gunnar Gundersen, M. D., of La Crosse, Wisconsin, a member of a family of eminent physicians, has served the State Medical Society of Wisconsin as Speaker of its House of Delegates, as its President, as a member of the founding Board of Directors of Blue Shield of Wisconsin, and as a member of many other committees concerned with the development of its scientific and economic policies; and

WHEREAS, In other capacities of citizenship, he has contributed a public service through membership on the Board of Regents of the University of Wisconsin and as a member and president of the Wisconsin State Board of Health; and

WHEREAS, Doctor Gundersen has served successively as delegate to the American Medical Association from Wisconsin, chairman of the Joint Commission on Accreditation of Hospitals during its two formative years, member of the Board of Trustees of the American Medical Association, chairman of its Executive Committee, and now in his second term on the Board as its chairman; and in addition, during the past three years, Doctor Gundersen has represented the American Medical Association on the Council of the World Medical Association; and

WHEREAS, This distinguished career amply attests to his qualifications to represent American medicine as President of the American Medical Association; now, therefore, be it

RESOLVED, That the Council of the State Medical Society of Wisconsin, assembled at Land O'Lakes, Wisconsin, on July 28, 1956, requests the Wisconsin delegation to present Gunnar Gundersen, M. D., of La Crosse, Wisconsin, to the House of Delegates of the American Medical Association for election to the office of President-elect of the AMA at its annual session in New York in June, 1957; and be it further

RESOLVED, That copies of this resolution be distributed to all members of the House of Delegates of the American Medical Association.

J. C. Grippit M.D.	R. E. Glassmith M.D.
Delegate	Alternate Delegate
W. D. Stovall	Charles E. Koepp M.D.
Delegate	Alternate Delegate
E. E. Gavin	L. O. Simenstad M.D.
Delegate	Alternate Delegate
Martin A. Wolle	Francis L. Bernhart M.D.
Delegate	Alternate Delegate

WISCONSIN CONGRESSIONAL DELEGATION honored Dr. Gunnar Gundersen, when he was seated as president of the American Medical Association in 1958, at a breakfast gathering in the Senate dining room, Washington, D. C. The Washington lawmakers were joined by representatives of the AMA. They are shown here, left to right, seated: Rep. John Byrnes, Green Bay; Dr. William Kennard, acting director of the Washington office of AMA; Sen. Alexander Wiley; Doctor Gundersen; Rep. Gardner Withrow, La Crosse; Sen. William Proxmire, Madison; and standing, left to right: Rep. Donald Tewes, Waukesha; William Van Pelt, Fond du Lac; Frank Huehl, an AMA official; Rep. Lester Johnson, Black River Falls; Rep. Melvin Laird, Marshfield; Rep. Clement Zablocki, Milwaukee; Rep. Alvin O'Konski, Mercer; Rep. Henry Reuss, Milwaukee; Dr. Cyrus Maxwell and Dr. Joseph Davis, both AMA directors.

A Dream of World Brotherhood

A DREAM OF world brotherhood with physicians taking leadership for world peace through the balm of the universal healing art was envisioned by Dr. Gunnar Gundersen when he took office as president of the American Medical Association in June 1958.

"Medicine, like religion, speaks a universal language which passes all barriers of race, creed, color, and nationality," he said in a speech on "Physicians of the World" at the inauguration ceremonies of the AMA in San Francisco.

Touching only lightly on controversial issues such as socialized medicine, Doctor Gundersen did say that doctors have a duty to "bring our weight to bear on the vital question of whether the individual or the state shall stand supreme in America's future."

Continuing with his inaugural address, Doctor Gundersen took note of the pace of the modern world, its new scientific complexities, and the difficulties of physicians in keeping abreast of new developments ranging all the way to "space medicine," but he said also that physicians nevertheless "should never forget their responsibilities to all humanity."

"We physicians have a unique opportunity to provide a spark of leadership which can help bring the world closer to the dream of world brotherhood," he said.

Speaking to the 15,000 doctors in attendance at the session, Doctor Gundersen said, "If you do not feel the compulsion of that task, I can only remind you of the Sputniks, Explorers, and Vanguards whirling overhead.

"If our alternative is destruction or a dream, the only sensible choice is to make the dream work."

A MEMORABLE MOMENT in Dr. Gunnar Gundrsen's life was the opportunity to meet and visit with the President of the United States, Dwight D. Eisenhower, shown here at the left with Doctor Gundersen, when President Eisenhower came to Atlantic City, N. J., in 1959, to address the American Medical Association when Doctor Gundersen was its president.

STATE MEDICAL SOCIETY OF WISCONSIN

created by an Act
of the Territorial Legislature
of 1841
Madison, Wisconsin, U.S.A.

Know all men by these presents that on the occasion of its 125th Anniversary Meeting in La Crosse, Wisconsin, this Society takes singular pride in making known its adoption of the following statement and action:

Gunnar Gundersen, physician and surgeon, of La Crosse, Wisconsin, is a tower of strength to his medical profession and to the public it serves, state and nationally.

It is the privilege of the State Medical Society of Wisconsin to pay tribute to this fine physician on the occasion of this May 12 meeting of the Wisconsin Surgical Society, of which he is a founder member, and during this year 1966 . . . the one hundred and twenty-fifth anniversary of the State Medical Society of Wisconsin.

To give another award to Gunnar is like bringing coals to Newcastle.

He has been our state president, he has been a trustee of the American Medical Association and chairman of its board, and he has been president of that great national medical organization. He has been the recipient of our Council Award, the highest award within the power of the State Medical Society to bestow upon one of its members.

Nonetheless, we feel that still another appropriately is due . . . one which memorializes his services to the science of medicine . . . one which commits posterity to recognition that service to the public weal is one of the great privileges of the medical profession.

To do this, the State Medical Society of Wisconsin announces the creation of the Gunnar Gundersen Gold Medallion Award, to designate an outstanding teaching exhibit in connection with the Society's annual meeting, and to be granted to such as may merit it in the years ahead.

In his profile of the physician and surgeon, the family advisor, the builder of high quality medical care, the teacher and the preceptor, the medallion will be awarded by our Commission on Scientific Medicine. The first award will be given in 1967.

All of medicine . . . La Crosse, Wisconsin, national and international, is grateful to Gunnar Gundersen, M.D. As chairman of the Council of the State Medical Society, it is a privilege to announce this award tonight, and in doing so, to acknowledge the quiet and unassuming help of his good wife, Mary, whose understanding and loyalty have helped Gunnar in his dedicated and selfless attainments.

James C. Fox M.D.
Chairman of the Council

Attest:

Ad Crownhart
Secretary

Thinking Ahead 100 Years

The following story is reprinted from the May 1959 issue of the *Wisconsin Medical Journal*. It reports Doctor Gundersen's remarks at the annual banquet of the State Medical Society of Wisconsin when he was president of the American Medical Association.

A PRESIDENT of the AMA represents to the public all of organized medicine in the United States.

Within the AMA he represents something more: he is the product of all organized medicine in his home state, and more or less on the spot for its conduct.

As AMA president Dr. Gunnar Gundersen began his annual banquet address Wednesday night he had a few words to say of Wisconsin's conduct: "I am deeply impressed with the things you are doing here." He cited the work of the SMS Foundation as one example.

Then: "I have visited many state societies in the past year, yet I know of no society which is assuming leadership the way this society is!"

But when he got to the subject of low-cost voluntary health insurance for the aged, with which his tenure of office will always be associated, President Gundersen really beamed with pride over Wisconsin's conduct.

He noted that the SMS had its insurance for the aged in operation in less than five months after the AMA proposal last December.

Century Plan. "And when you named your plan the Century Plan," said Dr. Gundersen, "you were thinking ahead a hundred years!"

The subject proved to be the theme of his address. Dr. Gundersen pointed out that in Benjamin Franklin's day the average lifespan was 35 years. Now it is more than twice that much. Today, he said, one out of every 11 citizens are past 65. By 1980 it will be one out of seven.

But advanced age poses new problems, he went on, and because medicine is indirectly responsible, it has an obligation to try to solve them.

"Certainly, health care for the aged is one of our most urgent challenges. But where an urgency exists, I believe an opportunity also lies . . . opportunity awaits he who will conquer the urgency."

Dr. Gundersen commended U.S. medicine for seizing opportunity and developing a program for low cost aged insurance.

He stated, "It is rooted in the traditional American concept of *voluntary* action by the individual. There is no

compulsion, no financial burden on others, no dependency on the government, no drain of tax funds."

"A foolish philosophy." Because of such concrete steps to provide needed help in the health insurance field, said Dr. Gundersen, medicine will oppose the . . . "foolish philosophy of 'pass-a-law-and-raise-the-social-security-tax-again.' "

But, he stated in conclusion: "Regardless of how fine a plan we develop, regardless of how enthusiastically we talk about it, its success, and the success of the American medical profession, depends on what you and I *do* about it. If our plan is to succeed, if medicine is to earn the gratitude of the nation's aged and of the future generations of senior citizens, each one of us must do more than pay lip service.

"You and I must make this plan work!"

Understanding Hearts

Excerpts from a feature article in *The Lutheran Brotherhood Bond*, February 1959 issue, at the time Dr. Gunnar Gundersen was president of the American Medical Association.

"Dr. Gunnar Gundersen, a tall, easy-mannered man of 61, advises young doctors to carry understanding hearts as well as skilled hands into their practice.

"In his 38 years of practice at La Crosse, Wis., Dr. Gundersen says he has tried to look upon each patient as a friend or potential friend.

" 'By attempting honestly to be a friend, I usually convince my patients that I really care about their problems,' he explains.

"The top spokesman for American medicine believes that the growing kinship with religion has made medicine realize that crisp, cold, purely scientific methods are not enough.

" 'Taken alone, such methods satisfy neither physician nor patient,' he said last spring at the dedication of a Lutheran mental health clinic in Brooklyn, N. Y.

" 'They do not constitute a rounded, complete concept of healing. There must be warmth, sympathy, understanding and faith.'

" 'Sometimes what we need most in the sickroom is not the medicine we prescribe. It is the faith and hope that we can instill in our patients through our own belief in a Power greater than all the instruments of science.' "

GUNNAR GUNDERSEN GOLD MEDALLION AWARD Recipients

1967

JOSEPH C. DARIN, MD
Wauwatosa
Assistant Professor of Surgery
Marquette School of Medicine
Milwaukee

1968

FLAVIO PULETTI, MD
Madison
Associate Professor of Surgery
University of Wisconsin Medical School
Madison

1969

ALLEN J. POIS, MD
Department of Cardiovascular Surgery

JOHN MORLEDGE, MD
Department of Internal Medicine

GORDON A. TUFFLI, MD
Department of Pediatrics

PETER RANK, MD
Department of Radiology

JACKSON CLINIC

METHODIST HOSPITAL
Madison

A Look at Tomorrow

By GUNNAR GUNDERSEN, MD

In 1962 Doctor Gundersen was invited to address the graduating class of Stritch School of Medicine of Loyola University, Chicago. This is the talk he gave. It was a significant message then; it remains so today. Its philosophy will be equally meaningful as long as there are newly-graduating physicians to discover it and veterans to be replenished by it.

WHENEVER I AM INVITED to speak to a group such as this and I search for a few illuminating and original thoughts to lay before my audience, I become painfully aware that none of the traditional graduation bromides are suitable to a class in medicine. It is an unwritten law that most graduating classes get a chance to be told

1. The hard work they have completed will result in an abundance of all the better things in life.

2. That a world awaits, breathless, for them to come and spread their pearls of wisdom.

3. They are ending the happiest years of their lives.

This line is a little hard to sell to a class of medical school seniors. It is true that you *have* worked hard and well to get this far, but I'm afraid you'll work even harder to continue your career. So that point is inappropriate.

Neither can I promise that the world is waiting for you, because the world has a way of not caring very much. Besides, there are those who would bet that *it* will change *you,* if changes are made.

Finally, were I even to hint that your memories of these past four years will seem anything but hours of trauma, you would personally escort me to the door!

Maybe we shouldn't *call* it graduation when we apply it to medical students. Nothing much is changing, really. You are continuing to move up in a way of life you began with your first course in pre-med or when you signed up for the science sequence of studies in high school. Your graduation ceremonies will be merely a further and more public acknowledgment of your slavery to our master, Medicine. And each of us in this room should be eternally grateful that we have been permitted to wear our chains.

No other profession bestows on man such awesome power over life and death. None other permits us to serve such a large number of our fellowmen so intimately and so personally. Few others impose so high a price of devotion, love and time. This has been the record of our calling for centuries, for the demand that a doctor must do all in his power for the well-being of his patient, regardless of the consequences, goes back to the cult of Aesculapius. His concern for the health of the community as a whole dates back to the cult of Hygeia.

Through these centuries humanity has undergone wars and rejoicings; nations and even races have been born, lived and disappeared. Yet the moral and ethical laws which the man of medicine is privileged to obey have remained unchanged. Down through time each doctor has shouldered his share of the weight of those laws and held it relatively steady as he bucked traffic. A heartening number of us have ended their days with nothing worse than contusions and abrasions, still worthy to be called "Doctor".

Now it is your turn. What has been prepared for you and what will you help to develop? Before we go into it, I would like to point out a truth that is

THE SIX PHYSICIAN SONS of Dr. Adolf Gundersen are shown here with their parents and sister: standing, from left, are Alf, Sigurd, Trigve, Tharalf, Gunnar, and Svenn. The sister, Helga (seated, center), is now Mrs. C. F. Midelfart. The seventh son, Bjorge, lives in Norway.

THREE GUNDERSEN SONS with father, Adolf (second from left)—Drs. Trygve, Gunnar, and Alf Gundersen, taken in 1930.

normally held secret until much later in your practice: It is much easier to tell what *has* happened than what is *about* to. Thus, if I lean a little heavier on what medicine has done so far, rather than what it will accomplish in the next few years, I am merely giving full diagnosis and a qualified prognosis. It can get you out of a lot of tight spots.

In a quarter century medical science has produced sulfonamides and antibiotics and fluorides. We use vaccines against polio, typhus, pertussis and yellow fever. We have gained control over cholera, typhoid, smallpox, diptheria, pneumonia, scarlet fever, tuberculosis. We prescribe vitamins and niacin, riboflavin and thiamine, antihistamines and tranquilizers.

In three decades we have reduced the incidence of maternal deaths from 65- to 5- out of 10,000. We have brought mental disease out in the open where we can treat it in the light of day. Ours are the finest hospitals in the world with the most advanced diagnostic and therapeutic equipment. We do things in surgery that were only dreams in the 1940s.

And the best may be yet to come. There are said to be some 6500 medical and technical journals being published in the world today (most of which will try to sell you a subscription on the day you open your office), and all of which predict that, technologically speaking, there seems to be no limit to our medical future. I am wary of such exuberance, but I will say that I look forward to the extensive use of closed-circuit television in education, in long distance consultation and conversation. (And just think what it would mean if we could call in Dr. Zorba before we scrub!)

Hospitals will utilize automation to increase effectiveness and decrease costs. Electronics and atomic energy will be used extensively in the diagnosis and treatment of disease.

Synthetic foods will be an important part of diet and nutrition. Chemistry will play an increasingly important role in bringing new tools with which to detect and fight pathological processes in the body.

I believe, too, that we can expect a better understanding of arteriosclerosis, coronary disease, hypertension, chronic nephritis and rheumatic fever. Leukemia and certain types of cancer will be amenable to cure.

Certainly, then, you have chosen a bright moment in medicine to make your entrance. How will the human element react? Will the slaves to the master be up to their tasks?

I believe that you will. Your teachers and administrators share that faith, or none of you could have come this far. The demands which medicine will place on you are different from its demands on my generation. The direction in which you must bend, the circumstances under which you must be firm, the changes you must make in order to keep your heritage unchanged, differ greatly from those required of graduation classes 20 or even 10 years ago.

The most basic fact is that in an age of increasing medical specialization, today's doctor must nourish an intellect that makes him not just a doctor, but

MEMBERS OF THE GUNDERSEN CLINIC STAFF shortly after the death of Dr. Adolf Gundersen in 1938—Back row, left to right: Drs. E. S. Carlsson, Sr., M. Sivertson, John Harman, Gunnar Gundersen, and Thorolf Gundersen; front row: Drs. Alf and Sigurd Gundersen, Paul Gatterdam; and Perry Walters.

GUNDERSEN FAMILY MEMBERS on the Gundersen Clinic staff posed for a recent picture—Standing, left to right: Drs. A. Erik Gundersen, Cameron B. Gundersen, Christian F. Midelfort, Sigurd B. Gundersen, Jr., and Thorolf Gundersen; seated, left to right: Drs. Alf H. Gundersen, Sigurd B. Gundersen, and Gunnar Gundersen.

educator, confessor and counsellor, analyst and Dutch Uncle to a degree that outstrips those demands on us older doctors. He may specialize, but he is apt to find more problems of the whole man to test his vision.

When I began practice, if someone came to me with a pain in the lower right abdomen, I was relatively safe in assuming it was either appendicitis or green apples. Today, in addition to these two possibilities, it is also highly probable that the patient is suffering—really and acutely—from the fact that his wife of 40 years wants to leave him to join the Peace Corps or Richard Burton. Or the man might have Stockholders' Syndrome or Krushchev Colic. It will be up to you to find out, for regardless of your particular practice, I can expect all of you to have as a secondary specialty, a very practical education in the symptoms of pressure.

Paradoxically, you will find equal challenge in the diseases of leisure, again to a greater degree than did those before you. As a genre, such illnesses are infinitely older than those developing from overwork. Our society has more free time and less idea of what to do with it than any other since the Romans, and we are trying for more. As it comes, we put it to use via such social activities as divorce, juvenile delinquency, TV-watching and hypochondria. Its ills are real and they are increasing.

FOR RELAXATION Doctor and Mrs. Gundersen love to work among the flowers and trees on their secluded farm known as "Glen Cameron."

Regardless of the cause or degree of his troubles, you will discover that while the patient wants the best and most modern treatment available, he is also badly in need of the old-fashioned friend that a doctor has always personified and which you must continue to be. In his mind's eye, the patient sees you as in the old paintings or in his real memories—rumpled and kindly, roused from your bed at 3 in the morning to come to his home and pull him through a crisis without so much as a Reader's Digest for medical reference. You will treat him in the clinic or the hospital whenever possible because the care you can give is far better in those facilities. You will try to avoid night calls because you know you can diagnose better with your eyes *open*.

But if, despite this efficiency, your concern for the patient has decreased one whit from that shown by the doctor of his memory; if your sympathy is shallower; if your love is less obvious, then you are dangerously careless with the trust for which your profession has stood all these years. And if you see modern medical advancement as the chance to treat your patients with less than *full* devotion *even for one day*, then I suggest you go no further with your plans. A good doctor can be mildly detached from his duties with the same success a wife can be mildly pregnant.

One group of patients which you as new doctors will work increasingly is the older group. Their number has been vastly expanded in recent years, thanks to science. Now our profession must see to it that the added years we give are not wasted. Or, as one authority puts it, that we have not "created a number who cannot derive either profit or pleasure from existence, and whose survival creates painful burdens for the community." Along with your many other accomplishments, to prevent this end, you will become more involved in geriatrics than those who have gone before you.

Of course, in these parallel interests you will not be expected to work alone. There will be the specialists—teachers, psychiatrists, therapists, community leaders—to carry the greater share of the responsibility, but it is up to you to do your part. So let your citizenship show!

Your long and intense medical education has equipped you to assemble, sort and evaluate information, to reject nonessential facts and to arrive at sound, logical, unbiased conclusions. This can make you an asset to your community in dozens of ways—on service clubs, Chambers of Commerce, citizen commit-

tees, youth programs such as 4-H Clubs, Boy and Girl Scouts.

Equally important, your education gives you special intelligence which must be shared with the community, in such areas as public health services, sanitation, living conditions, recreational facilities, child training, child psychology and countless other aspects of the general environment.

In recent years many independent doctors' groups have formed around the country to work in behalf of good government at the local level and to elect candidates who stand for those democratic principles of government in which we believe. Don't ever consider such activities as out of your balliwick. As citizens, we owe it to our country and our profession to maintain a steady, nonpartisan interest in local, state and national affairs, demonstrating that we are sincerely concerned with all aspects of public welfare.

Then it almost goes without saying that you must be diligent in your efforts to educate the patient and the community in the acceptance of the vaccines and preventive medicines of tomorrow. The development of polio vaccines is well within our memories—the newspaper headlines, the well-earned laudatory speeches and editorials to Doctors Salk and Sabin. Yet today there are *still* cases of polio cripplings and even deaths. The reason is simply that somewhere along the line the education processes bogged down. Too many people—virtually all of them who appear as morbidity statistics—were blind to the necessity for immunization. They might have seen—and consequently walked and lived—if their doctors had been more venement. Don't look to the public to be too wise, ladies and gentlemen. To have disease is a tragedy. To have an unused preventive is a crime!

My only other prediction is one that fits all the profession as a whole and for which we must be thankful. I'm sure you will have already experienced it in your clinical work during these past years. That is the fact that society will hold the doctor on a plane with its most respected figures.

Most of us know we don't deserve such adulation, but most of us find ourselves stimulated by it and setting our lives to merit it. Someday a few of us might live up to that goal, working as tirelessly as we know we should, as chary of misjudgment as we are of misconduct, and aware that the most brilliant and productive of us is merely an instrument of service. Each of us has a right to what success honestly comes our way. None of us needs ever apologize if long years of service result in the ability to give our family some of the better things in life. The danger begins the day those "better things" becloud our vision of why we serve.

Service is the spur. We don't know why it is ours in the form it has taken, and we will be puzzled from time to time to find that we cling to it against often overwhelming odds. Service is the explanation for the nights we will go without sleep. It is the gilding on what other rewards we may earn. It can be our only consolation when consolation is badly needed.

Seventy-one of you have been stung by the need to serve. What a fine day this will be for medicine if, among my predictions for the future, I can say that the sting will increase in each of you. That is my prayer today, and "more I cannot wish you."

NORWEGIAN–AMERICAN RELATIONS have been closely maintained by the Gundersen family, and it is only natural that one of them, Dr. Gunnar, was president of the Norwegian–American Museum at Decorah, Iowa. In 1965 when Crown Prince Harald of Norway visited this country, Doctor Gundersen gave him a tour of the Museum. He is shown here at the right with Doctor Gundersen and Marion Nelson, Museum director. In 1966 Doctor Gundersen was honored by the Norwegian–American Museum, at a reception in New York City, in connection with its 90th anniversary program.

GUNNAR GUNDERSEN, M.D.

Dr. Gunnar Gundersen was the first president of the Norwegian–American Museum corporation, serving from its inception in 1964 to his resignation in 1967. He was a key figure in establishing this institution which has assumed responsibility for the extensive immigrant collection in Decorah and has built up a Museum program of national scope.

Doctor Gundersen's enthusiasm for this project, his keen administrative ability, and his broad recognition and respect throughout the United States and Norway has made him of invaluable significance to the Museum.

The Norwegian–American Museum is proud to join the Wisconsin Medical Journal in honoring Dr. Gunnar Gundersen for his many years of constructive involvement in institutions of widely varying types dedicated to the betterment of humanity.

Marion Nelson
Decorah, Iowa

A man with ability to write his own speeches

A partial listing of Dr. Gunnar Gundersen's major addresses follows:

Changing Role of the Physician in the Hospital of the Future, *Hospital Management,* Nov. 1952.

The Doctor's Stake in Hospital Accreditation, before the Midyear Conference of the American Hospital Association, Chicago, Ill., February 1954, and published in *JAMA,* Mar. 13, 1954, and *Trustee,* May 1954.

The Physician and World Peace, *World Medical Journal,* May 1956.

The Physician in the World Today, delivered at Forum Session, Fourth Annual Meeting of National Citizens Committee for the World Health Organization, Atlantic City, N. J., Nov. 14, 1956.

It Takes Two, delivered before American Association of Public Health Physicians, Cleveland, Ohio, Nov. 14, 1957.

AMA's Design for the Future, at North Central Conference, Minneapolis, Minn., Nov. 24, 1957.

Thank You, Sputnik, before the Scientific Conference, Brain Research Foundation, New York City, Jan. 25, 1958.

The Treasure and the Key, at Convocation, University of Iowa College of Medicine, Iowa City, Iowa, June 12, 1958.

Looking Back on Tomorrow, at Recognition Exercises, University of Minnesota Medical School, Minneapolis, Minn., June 13, 1958.

Remarks to Woman's Auxiliary to Washington State Medical Association, Sept. 16, 1958.

Selling the Pass, before Washington State Medical Association, Spokane, Wash., Sept. 16, 1958.

The Stature of Medicine, dedication of the David Whitney House, Wayne County Medical Society, Detroit, Mich., Sept. 27, 1958.

The World Medical Association Today, before Woman's Auxiliary to the AMA, Chicago, Ill., Oct. 7, 1958.

The American Medical Association—Medical School Partnership, at Sixth Annual Meeting, Association of American Medical Colleges, Philadelphia, Pa., Oct. 13, 1958, and published in *Journal of Medical Education* 34:8–13 (Jan) 1959.

Today's Problems, Tomorrow's Freedom, at Marshfield Clinic, Oct. 25, 1958.

Welcome Address, at Fifth Annual Conference, Mental Health Representatives of State Medical Associations, Chicago, Ill., Nov. 21, 1958.

Presentation Address, before National Fund for Medical Education honoring Frank W. Abrams, New York City, Sept. 30, 1958.

The Profession's Civil Defense Responsibilities, before AMA Civil Defense Conference, Chicago, Ill., Nov. 9, 1958.

President's Address, at Opening Session, House of Delegates, AMA 12th Clinical Meeting, Minneapolis, Minn., Dec. 2, 1958.

Welcome Address, at Opening General Assembly of AMA Annual Clinical Meeting, Minneapolis, Minn., Dec. 2, 1958.

Medical Progress for You, before Minneapolis Rotary Club, Minneapolis, Minn., Dec. 5, 1958.

Address at Los Angeles, before District 1 of the Los Angeles County Medical Association, 1959.

Medicine's Blueprint for the New Era of Aging, 1959.

Importance of Increased Use of Polio Vaccine, before Scientific Symposium on Polio Vaccine, University of Michigan, School of Public Health, Dept. of Epidemiology, Ann Arbor, Mich., Jan. 6, 1959.

The American Medical Association and the American Medical Education Foundation, before Annual State Chairmen's Meeting of the AMEF, Chicago, Ill., Jan. 24, 1959.

New Directions in '59, before Board of Chancellors and Councilors, American College of Radiology and Chicago Roentgen Society, Chicago, Ill., Feb. 5, 1959.

DR. GUNNAR GUNDERSEN confers with a son, Gunnar, Jr., a radiologist, on the steps of the old clinic. Doctor Gunnar's other son, Cameron, is an internist. Both are associated with the Gundersen Clinic. The Gundersens also have a daughter, Mary, who lives with her lawyer husband in Oslo, Norway. (Photo courtesy of the Minneapolis Sunday Tribune, Sept. 29, 1957 issue)

GUNNAR GUNDERSEN, M.D.

I feel very honored at being able to add my few words in tribute to Gunnar Gundersen, M.D. of La Crosse, Wisconsin. I am sure I do not have to go into his many activities as they undoubtedly will be reported in detail in this magazine.

In La Crosse County, Dr. Gundersen has been held in great esteem and affection by his medical colleagues. His many years of time and effort extended freely, not only for the medical profession but for other civic, state and national institutions, has provoked great admiration among all of us.

To me he has been a kind, personal friend, and I have sought his advice on many occasions. I am happy and proud to join you in saluting this great physician and gentleman.

James C. Fox, M.D.
La Crosse

Welcome Address, before 55th Annual Congress on Medical Education and Licensure, Chicago, Ill., Feb. 7, 1959.

Medical Responsibilities in a Changing World, before the Federation of State Medical Boards of the U. S., Chicago, Ill., Feb. 9, 1959.

An Age-Old Problem, before Oklahoma State Medical Association, Tulsa, Apr. 19, 1959.

Truth and Consequences, before the Medical Assistants Society of Oklahoma, Tulsa, Apr. 19, 1959.

Land of the Free and Easy?, before the Texas Medical Association, San Antonio, Apr. 21, 1959.

Exile for the Elderly?, before the Iowa State Medical Society, Des Moines, Apr. 22, 1959.

Don't Fence Them In, before Medical Society of State of New York, Buffalo, May 11, 1959.

Welcome Address, at School Health Session, AMA, Atlantic City, N. J., June 7, 1959.

Presentation of Goldberger Award, AMA House of Delegates, June 8, 1959.

House of Delegates Report, at Opening Session, House of Delegates, AMA's 108th Annual Meeting, Atlantic City, N. J., June 8, 1959.

Medicine Everywhere is Everyone's Concern, at Woman's Auxiliary to the AMA, Atlantic City, N. J., June 10, 1959.

Only Our Best, before the 79th Annual Meeting of the Louisiana State Medical Society, New Orleans, May 4, 1959, and published in *Journal of the Louisiana State Medical Society* 111: 237–240 (July) 1959.

American Medical Association Report, *Public Health Reports* 74:615–620 (July) 1959.

Variations on a Theme, *Woman's Auxiliary Bulletin*, September 1959.

Don't Let the Side Down, at 23rd Annual Meeting, Mississippi Valley Medical Society, Chicago, Ill., Sept. 25, 1959.

The Doctor and Voluntary Health Insurance, at Annual Meeting, International Claim Association, Miami Beach, Fla., Sept. 28, 1959.

The Socio-economic Responsibilities of Medicine, Liberty Mutual Insurance Symposium—"The Growing Challenge of Disability Control in an Era of Comprehensive Medical Care," Boston, Mass., Oct. 15–16, 1959.

Evermore or Nevermore?, Annual Carle Foundation Lecture, Urbana, Ill., Nov. 5, 1959.

Why a Medical Political Action Group Is Needed, *New Medical Materia*, September 1961.

GUNNAR GUNDERSEN, M.D.

This is a special privilege and pleasure to have the opportunity to greet you and extend congratulations for the distinguished career you have wrought in the practice of medicine and surgery and in public service. You have been given every high office in state, national and world medical organizations and positions of responsibility in public office. In all of these you have shown wisdom in influencing the shape of public policy and effective leadership in accomplishing your plans.

Now I cannot let this opportunity pass without expressing also a personal note of deep appreciation for the friendship which has grown between us through the years as we have traveled here and there.

William D. Stovall, M.D.
Madison

Adding Life to Years

Excerpts from an address given at the Second Governor's Conference on Aging, June 4, 1958.

"THE PROBLEM OF medical science is no longer, as it was in the earlier decades of this century, one of adding years to life. It has become one of adding life to the years.

"Our greatest challenge lies not in how many years we can stay alive, but rather in the positive, rewarding living we are able to put into those years, especially the later years.

"We must learn to think in terms of how well a man is rather than how sick he is.

"Each new study reconfirms our feeling that our solutions ultimately will not be found in the laboratory. Rather, they are more likely to come from the efforts of volunteer community agencies and individuals.

"From a medical standpoint the greatest hope that we can extend to our senior citizens for continued good health is continued activity and purposeful endeavor.

"Through the practice of preventive medicine, doctors may be able to eliminate earlier in life many of the medical problems now confronting the aged.

"The day is close at hand when physical and mental deterioration will no longer be a concomittant of the aging process.

"We can eliminate much illness if we merely institute regular examination programs for our senior citizens.

"Perhaps in our lifetime, we shall achieve the ultimate goal of making old age the best years of a long life, when the accumulated wisdom of the years pays its most generous dividends."

—*Gunnar Gundersen, MD*

DR. GUNNAR, as he is fondly called in La Crosse, chats with a patient in the clinic at the time he was president of the AMA. (Photo courtesy of the Minneapolis Sunday Tribune, Sept. 29, 1957 issue)

Council *Award*

STATE MEDICAL SOCIETY OF WISCONSIN

Annual Meeting • Milwaukee • October 7, 1953

Presentation Made by R. G. Arveson, M. D.
Chairman of the Council

The broad responsibility of looking after the health of man rests upon many shoulders among those who have chosen to make medicine their profession. It is natural that most physicians have found their opportunity for service to humanity in the art and science of healing the sick. True, some combine the practice of medicine with research and teaching, while others may devote themselves exclusively to these vital spheres of professional activity. Still others find an unusual challenge in the opportunities for service in public health, in the organizational affairs of medicine, and in the socio-economic problems related to health. Not infrequently, medicine's genius for progress in these fields stems from a number of physicians in whom their colleagues have placed far more than usual reliance and authority. They are very often men who find responsibility the fertile soil of accomplishment.

Among these men of medicine are some whose responsiveness to the needs of the people and the medical society is evidenced by exceptional and faithful service far beyond the call of office. Theirs unquestionably is a work of love and a reward of satisfaction.

For such as these among its members, the Council has established a noble tradition for expressing its appreciation and high regard through the granting of the Council Award. This, the highest award of the State Medical Society of Wisconsin, is granted only upon occasion, and then only by unanimous vote of the Council. To this date, only 22 such awards have been made. Tonight, by direction of my fellow Councilors, we give another:

Dr. Gunnar Gundersen of La Crosse, will you please rise?

Gunnar Gundersen, a native son of Wisconsin, an eminent surgeon and leader in medicine, a graduate of the University of Wisconsin and Columbia University College of Physicians and Surgeons, formerly a member of the Board of Regents of the University of Wisconsin and for many years a preceptor of its medical school; a member of the Wisconsin State Board of Health from 1943 to 1951 and for five years its president; former member of the Committee on Industrial Health and the Committee on Public Policy of the State Medical Society; president of the Society in 1942; speaker of its House of Delegates in 1947 and 1948; a member of the first directing board of Wisconsin Physicians Service serving from 1946 to 1951; a member of the Board of Trustees of the American Medical Association for the past five years and currently chairman of its Executive Committee; and American Medical Association representative on the Joint Commission on Accreditation of Hospitals and chairman of the Commission during its two formative years; member of the Council of the World Medical Association; a valued leader in the affairs of the American College of Surgeons, the American Board of Surgery, the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

For your extraordinary influence in the development of better medical care for the people of Wisconsin and the nation, for your devotion to the practice of medicine while at the same time lending much to its scientific and economic development, for your understanding and vision in problems of medical organization and service, and for your zeal to bring about professional regard for the social and economic values in the everyday practice of the healing art:

We, your fellow members, give you this seal of our Society as a token of your achievement and of our esteem and affection.

A GUNDERSEN CLINIC STAFF GROUP—Back row, left to right: Doctors Carlsson, Ramlow, Sitterson, Sigurd Gundersen, Ridout, Harman, Sivertson, Butler, Gunnar Gundersen, and Thorolf Gundersen; front row: Doctors Gatterdam, Midelfort, Harris, Schaffer, Alf Gundersen, Perry, Bruder, and Davies.

Medicine and the Community

An excerpt from the 75th Anniversary issue of the *Journal of the American Medical Association*, July 12, 1958.

The future will see even greater emphasis on disease prevention, maintenance of good health, and effective rehabilitation of the disabled. Technological advances, aided in great measure by new developments in electronics and atomic medicine, will reveal a multitude of facts concerning cardiovascular diseases, cancer, mental and nervous disorders, and various chronic ailments. An increasing proportion of medical services will be provided through clinics, medical centers, and various types of group practice. There will be interesting new developments in the design and operation of hospitals. Voluntary health insurance, if it is not destroyed by government ventures in compulsory health insurance, will solve the problem of medical care costs for all the people of the United States except the indigent. The latter, as always, will be taken care of by private and public charity, and it may be possible that plans for the indigent also will be financed on an insurance basis.

The future of American medicine is bright, if we can continue to work in an atmosphere of freedom, motivated by the dual spirit of enterprise and cooperation. The dominant socioeconomic challenge of the present is to preserve that atmosphere and that spirit.—*Gunnar Gundersen, MD*

GUNNAR GUNDERSEN, M.D.

Obviously, you have come of age and merited honors are being heaped upon you. May I add that no man of my acquaintance has greater claim to the distinction of this Commemorative Issue of the *Wisconsin Medical Journal* than you.

It has been my privilege to know three generations of Gundersens and their mark upon the community and the profession of Medicine has been conspicuous. Really I feel that I have an unusual privilege in the continuity of our friendship, which dates from your undergraduate period at the University. Of course, I was "never strong for the Betas" but I do make exceptions!

While the Preceptorship at La Crosse has been a point of common interest, your activities in organized Medicine in the state, nation, and internationally have left a distinct impression on every group, with which you have been associated. You may recall that I served with you for a short period on the Joint Commission on Accreditation of Hospitals. It was a source of deep gratification to me to find your counsel so widely sought. You are in the true sense of the term a Medical Statesman whose works will last well beyond your lifetime.

It is my sincere wish that your years may be long and healthful. It is an unusual privilege to add my small voice to the chorus of acclaim in your honor.

Warm personal regards.

William S. Middleton, M.D.
Madison

A Motivating Force in Gundersen Clinic

During the fifty years in which Dr. Gunnar Gundersen has distinguished himself as a great physician and surgeon in his native city of La Crosse, he also has been recognized as a prime motivator in the development of the Gundersen Clinic and La Crosse Lutheran Hospital as a leading Midwest health center.

The Gundersen Clinic was established in 1927 by Dr. Adolf Gundersen and three of his sons: Drs. Sigurd B., Gunnar, and Alf H. Gundersen. A fourth son, Dr. Thorolf Gundersen, joined the clinic a few years later.

The Gundersen Clinic building, located next to the La Crosse Lutheran Hospital which is located on the southwestern margin of La Crosse overlooking the broad Mississippi valley, was built in 1929, and occupied in 1930.

In the years to follow, the clinic's staff and facilities continued to expand. Two additions to the Clinic building and two large additions to the Hospital were made. Now an entirely new Clinic building has been partially completed.

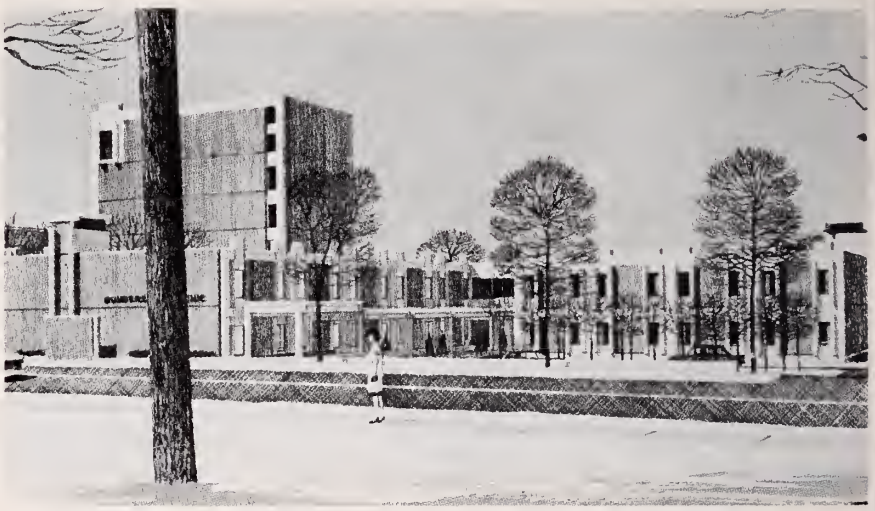
Over a period of years the Gundersen Clinic has been given to the Adolf Gundersen Medical Foundation which was "created to perpetuate the memory of Dr. Adolf Gundersen (1865–1938), pioneer physician and humanitarian; a master surgeon of great vision and faith who devoted fifty years of his life to serving the sick and ailing." The inspiration to create the Adolf Gundersen Medical Foundation came from Doctor Gundersen's three sons: Dr. Sigurd B., Dr. Gunnar, and Dr. Alf H. Gundersen.

Dr. Gunnar Gundersen is secretary–treasurer of the Foundation.

This nonprofit corporation, which was chartered in 1944, grants fellowships to young doctors for advanced study in specialized fields, provides facilities and modern equipment for such studies, and conducts investigations into the many unsolved problems of medicine and surgery.

To this end the Foundation continues to "pursue Dr. Adolf Gundersen's work and ideals with the same zeal and devotion for which he was distinguished."

Dr. Gunnar Gundersen followed his father in the preceptor program of the University of Wisconsin. His guiding influence on fourth-year medical students, who spend three months at the Clinic working with various members of the staff, has made a significant contribution to Wisconsin medicine.



THE NEW GUNDERSEN CLINIC when it is completed. The larger structure at the left has been completed and is in use. It is located to the right of the old clinic building. Dr. Alf H. Gundersen is president of the Clinic's board of directors.

ODE TO DR. GUNNAR GUNDERSEN

I have now known Gunnar Gundersen, Sr. fifty-one years, plus;
He is a fine gentleman and we were glad when he joined us.
When he was an intern he worked hard and also studied much;
He learned to practice medicine and surgery and all such.
After a great many years he decided to join the orthopods;
He did not believe in Bucks extension casts, like us other clods.
He started to nail hips and fractures, saving patients time and money;
All the patients were so satisfied, they called him a Honey.
He began a career in politics in which he had no peer;
After all the years in politics, he is without doubt a seer.
He worked hard for the county and state societies and the AMA;
For his dedication and work he deserves the top mark, "A".
And now, Gunnar, as I close, I hope that you like this poem of mine;
You have my wishes that each day may be bright with golden sunshine.

E. S. Carlsson, Sr., M.D.
La Crosse

THE NEW WING OF LA CROSSE LUTHERAN HOSPITAL, dedicated in 1966, is shown at the left with the old Gundersen Clinic building at the right.

Rubella Vaccine Reported Near Perfect

The "Cendehill" vaccine against rubella was found to be 97 to 100 percent effective in studies involving 16,000 Jamaican children, the largest single evaluation of a rubella vaccine.

Dr. Edward Belle, senior lecturer at the Department of Microbiology, University of the West Indies, Kingston, Jamaica, made the report recently in a paper presented at a meeting of the Medical Research Council of the Caribbean, Port of Spain, Trinidad.

The medical team from the University, under direction of Dr. Louis Grant, head of the Department of Microbiology, studied the vaccine, first in closed studies, later in family and open studies. There was no spread of the vaccine's live-virus from vaccinees to susceptible control subjects living in close contact with them.

Included in the studies were over 1,500 persons 13-to-18 years of age. There was no evidence of arthralgia or arthritis in them.

The "Cendehill" strain of rubella virus used in the vaccine was developed by Recherce et Industrie Thérapeutiques (R.I.T.), a Belgian subsidiary of Smith Kline & French Laboratories. Large-scale clinical trials have been organized jointly by SK&F and R.I.T.

The vaccine recently became the first German measles vaccine to be licensed in the world when approval was granted to R.I.T. in Switzerland by the Swiss Federal Service of Public Hygiene. It was expected that the vaccine, grown in primary rabbit kidney cell cultures and manufactured at R.I.T., would be available for general use in Switzerland by the end of May.

In the United States, an application for license is being considered by the Division of Biologics Standards of the U.S. Public Health Service.

The "Cendehill" vaccine has been given to over 100,000 persons, including 13,000 in the United States, in closed studies, family studies, and large-scale open studies in the Americas, Europe, the Caribbean, Asia and Africa.

In the United States, the most recent epidemic of German measles was in 1964–65. It resulted in about 20,000 birth abnormalities and fetal deaths. According to the cycle of the disease, another epidemic may occur in 1970–71.

FELLOWSHIPS IN CLINICAL NEUROLOGY . . .

have been established at the Minneapolis Veterans Administration Hospital.

General Practitioners and Nonneurological Specialists are invited to apply for an intensive postgraduate training experience on the Neurological Wards at the Minneapolis VA Hospital.

Programs are designed to provide one to four weeks of supervised bedside and didactic instruction in the diagnosis and treatment of neurological disease.

Fellows may elect any one or a combination of the following programs:

WEEK I: The Neurological Examination

WEEK II: Special Neurological Diagnostic Procedures

WEEK III: Latest Treatments of Acute and Chronic Neurological Problems

WEEK IV: Frontiers of Neurological Research

Each program will commence on Monday and terminate on Friday.

Please apply to Milton Alter, MD, PhD, Chief, Neurology Service, Veterans Administration Hospital, 54th St. and 48th Ave. So., Minneapolis, Minn. 55417.

Find your future in the HEALTH FIELD

. . . a career guide

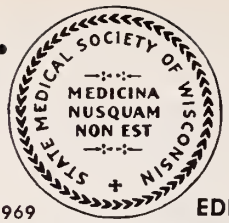
"Find your future in the health field," urges a brochure published by the Wisconsin Health Council, Inc. The brochure, developed with the assistance of the State Medical Society, contains information on 26 careers in health.

The publication is unique in its presentation. It is intended to supplement existing careers materials, and gives factual and statistical information on personal qualifications, educational requirements and opportunities, and employment possibilities in each of the fields. It places emphasis on Wisconsin.

Copies are distributed to guidance counselors in every Wisconsin school, and individual copies are available from the Wisconsin Health Council to youngsters interested in health careers.

Supplies are also available to physicians who participate in career days in their local schools; they may be obtained by writing the State Medical Society, Box 1109, Madison 53701.

The Wisconsin Health Council, which published the brochure, was formed in 1948 to stimulate citizen interest in public health in Wisconsin.

SECTION 

OPHTHALMOLOGY

NOVEMBER 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

MARQUETTE CLINICAL CONFERENCES

The Marquette School of Medicine Department of Ophthalmology holds monthly clinical conferences on the second Friday of each month from 8:00 a.m. to 10:00 a.m., Milwaukee County General Hospital, King Conference Room, 5th floor. The first hour consists of clinical presentation of diagnostic and treatment problems in ophthalmology followed by a brief CPC. During the second hour a member of the resident physician staff will present a paper on a subject of current interest in ophthalmology.

All ophthalmologists are cordially invited to attend these clinical conferences. If you have patients that you would like to present for discussion, please notify my office one week prior to the meetings. In general, clinical case presentations are limited to two patients so there is adequate time for discussion. We hope that these conferences contribute to the continuing education programs for the practicing ophthalmologist. Your participation is encouraged and appreciated.—RICHARD O. SCHULTZ, MD (Phone: 414/774–0505)

GLAUCOMA CLINIC, MANITOWOC

A Glaucoma Clinic was held at Holy Family Hospital, Manitowoc, on Sept. 20, 1969. The clinic was co-sponsored by the Manitowoc County Lions Clubs and the Manitowoc Braille Club. Four ophthalmologists did the examinations and these included Robert C. Randolph, MD, John T. Jiroch, MD, and Cyril J. Radl, MD of Manitowoc, and Robert D. De Cock, MD of Appleton. A total of 722 people were examined and 19 of these were found to have elevated pressures.—JOHN D. BEST, MD

WISCONSIN–UPPER MICHIGAN SOCIETY OF O & O

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology meeting at Lake Delton, Sept. 26–28, 1969, was attended by 30 members.

Dr. Joseph Haas of Chicago spoke on glaucoma. Dr. Henry L. Williams of Minneapolis, Minn., spoke on otolaryngology subjects.

New officers elected were: John V. Berger, MD, Madison, president; Dwain Mings, MD, Monroe, vice-president; and James Allen, MD, Madison, secretary-treasurer.

New ophthalmologists elected to membership in the society are: Jeffrey L. Warren, MD, Appleton; Kenneth A. Morrow, MD, Ashland; Albert V. Kanner, MD, Madison; and Michael J. Belson, MD, Green Bay.

The next meeting will be in Madison in September 1970.

WISCONSIN EYE ALUMNI ASSOCIATION

The alumni of the University of Wisconsin Ophthalmology Residency Program met Oct. 10. Speakers were: Robert C. Randolph, MD, Manitowoc; Matthew D. Davis, MD, Madison; Frank Myers, MD, Madison; Guillermo de Venecia, MD, Madison; Rodney Sturm, MD, Madison; Thomas Frey, MD, Washington; George Kambara, MD, Los Angeles; and Claude Miller, MD, Wenatchee, Wash.

MADISON LIONS EYE BANK

The Madison division of the Wisconsin Lions Eye Bank in the first four months of its existence has provided eyes for 23 corneal transplants, including three which were for emergencies. Four pairs of eyes were sent to the Illinois Eye Bank; three pairs were sent to the Milwaukee Eye Bank, and one pair was sent to Knoxville, Tenn., in response to an emergency request put on the Ham Radio Operators Network which relays such information daily to all Eye Banks throughout the United States. The Madison Eye Bank hopes to be able to provide an even greater number of eyes for corneal transplantation in the coming months.

NEW OPHTHALMOLOGIST IN MADISON

Dr. John Doty has recently joined the ophthalmology staff of the Dean Clinic in Madison. His preliminary education was accomplished at Wisconsin State University–La Crosse and at the University of Wisconsin Medical School. Afterwards he served a rotating internship at San Joaquin County General Hospital in Stockton, Calif., and then he returned to the University of Wisconsin Hospitals for his ophthalmology training which was completed in November 1969.

MARQUETTE RECEIVES RESEARCH GRANT

Marquette School of Medicine has received a $138,142 grant from the United States public health service for research of the cornea. The school's departments of ophthalmology and physiology will conduct the studies into the inherent transparency of the cornea and how it behaves in both normal and disease states. □

WISCONSIN MEDICAL JOURNAL
Vol. 68, No. 11 NOVEMBER 1969

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

State Mobilizes for Mass Immunity to Rubella

Wisconsin is mobilizing its health forces for a rubella immunization campaign. The initial "target population" are the children in kindergarten, first and second grade, and preschoolers in Head Start programs and day care centers.

The State Division of Health, with the aid of federal funds, has already made provisions to vaccinate this "target" group in the 19 Wisconsin counties which have the highest percentage of families earning less than $3,000 per year.

Physicians, county health nurses, and school officials are cooperating throughout the state in an attempt to set up inoculation clinics for the "target" group now, to be followed by a long-range rubella immunization program including all children, through 12 years of age.

According to health officials, cooperative efforts are necessary to accomplish this program. It would be impossible at this late date to vaccinate enough children through the regular patient/physician relationship, they state.

Also, they add that there is some resistance to private physician inoculation because of the cost and because parents do not fully appreciate the necessity for inoculation of their children. Therefore, physicians, as well as others on the health team, are being urged to help motivate parents and the community into taking advantage of the public immunization clinics.

In the future, infants may be routinely vaccinated during their second year of life. A single vaccination is believed to confer lifelong immunity.

With the joint efforts of physicians, public health nurses, schools, and parents, the 1964 rubella epidemic tragedies need not recur, health officials state.

RESOLUTION BY THE HANDICAPPED CHILD COMMITTEE OF THE WISCONSIN CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS —OCTOBER 3, 1969

As pediatricians we recognize the devastating effects rubella produces in a child when the mother contracts the disease early in her pregnancy. The recent availability of the long-awaited Rubella Vaccine gives the physicians in the state a chance to practice the most rewarding form of medicine—the prevention of a serious and life-long handicap in a child. Cases of deafness, blindness, congenital heart disease and mental retardation occurring as a result of this disease are all too familiar to us. The recent epidemic in 1964 has more than doubled the number of pre-school deaf children in Wisconsin. The prediction for another epidemic in 1970 or 1971 produces a sense of urgency for action.

The Wisconsin Chapter of the American Academy of Pediatrics urges all physicians in the state to adopt as a goal the immunization of all young children, especially those between the ages of 1 and 10, this year in their own offices or in public clinics. Control of the threatened epidemic is only possible when there is no longer a large population of susceptible children.

Alcoholism Symposium Dec. 5, Wood VA Center

Key people in alcoholism treatment and rehabilitation throughout the state will get together Friday, Dec. 5, at the Wood Veterans Administration Hospital, Milwaukee, for a research symposium.

Wisconsin physicians participating in the all-day program include Dr. Darold Treffert, superintendent of Winnebago State Hospital and chairman of the State Medical Society's Division on Alcoholism and Drug Addiction; Dr. M. E. Chafetz; Dr. S. Kaim, VA Central Office; Dr. G. Lysloff, director of research, Winnebago State Hospital; Dr. Arnold Ludwig, director of research, Mendota State Hospital; Dr. L. J. Ganser, Madison; Dr. Basil Jackson, chief of psychiatry, VA Center, Wood; Dr. Leigh Roberts, UW Medical School, Madison; and Dr. Sidney Shindell, Marquette School of Medicine, Milwaukee.

Conference chairman is Arthur S. Wilson, PhD, Marquette School of Medicine and Veterans Administration, Milwaukee.

1970 Could Be Epidemic Year for Rubella

Tension is mounting as statisticians predict 1970 to be an epidemic year for rubella, or German measles.

Once considered harmless, the disease is now the subject of nationwide control, because of its potential as a crippler and killer of unborn children.

To prevent or greatly reduce the effects of this epidemic an intensive program of rubella immunization is underway.

Rubella shows a seasonal increase in the spring, generally during the months of March, April, and May, with widespread epidemics every six to nine years. In Wisconsin, the last three rubella epidemics have occurred at six-year intervals. With the last epidemic occurring in 1964, steps must be taken now to prevent another pandemic peak in 1970.

The National Foundation—March of Dimes has estimated that on a national basis some 20,000 live babies had birth defects due to the 1964 German Measles Epidemic.

The Wisconsin picture shows definite damage to children as a result of the 1964 epidemic. It has been clearly established that there were six children born in 1964 and 1965 with brain damage and are now in Central Colony. If tests were done it would be proved that many more children in other mentally retarded facilities are there because of rubella.

The number of deaf preschool children reported to the State Bureau for Handicapped Children showed 65 born in 1964 as compared to 22 the year before, and 41 in 1965 as compared to 7 in 1966. There were six children born in 1964 and 1965 who were both blind and deaf—two cases are definitely attributed to their mothers having had rubella early in their pregnancies.

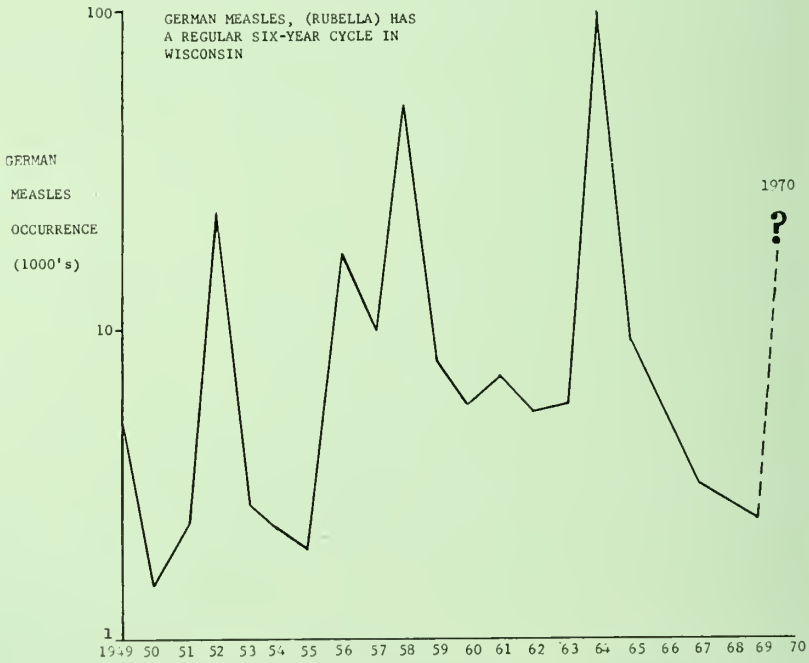
The damage done by rubella is not as easily identified as the damage done by polio; it doesn't come at the time of the disease, but shows up in the baby that she was bearing months after the mother contracted the disease.

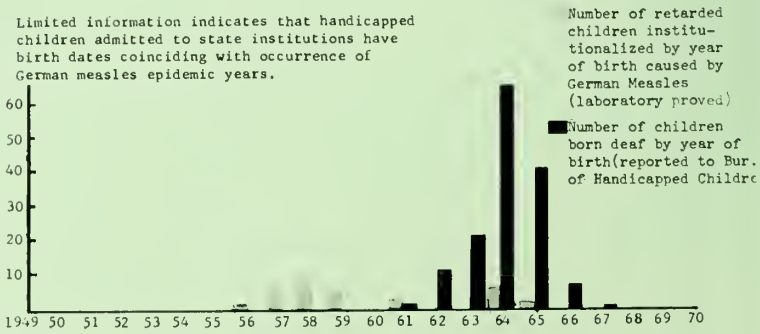
The damage is also a great problem to the community because special education is required for the afflicted children. This is a tax expense. It costs $3,609 a year to educate a child in the school for blind or the school for deaf; the cost is $6,000 a year for a child with the double handicap.

Pregnant women must not be given the vaccine because the viremia that follows vaccination and lasts two to six weeks may permit virus to pass the placental barrier and affect the growing fetus.

Protection of the developing baby against rubella infection must therefore be accomplished by preventing the spread of infection to pregnant women. Children are primarily resonsible for spread of the disease among themselves and to others.

Consequently, mass immunization for all children from age 1 through 12 seems to be the answer. All children in this age group have been considered susceptible to rubella, even though those in the upper half of this level may already be immune.





MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1969 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thoyer, Director of Socio-Economic Medicine.

Beer Tax Increase Keeps Marquette School Open

State Medical Society Plays Active Role

The struggle to keep open the doors of Marquette School of Medicine has been won. At least for two years.

Governor Warren P. Knowles signed Special Session Bill 4 (Chapter 185) on October 31 providing financial assistance to the school.

The law provides public support of the school in the amount of $1,500,000 for 1969–70 and $1,700,000 for 1970–71 for general program operations.

The assistance is financed by an increase in the beer tax.

In a statement to the Governor the day of the signing, Dr. W. T. Russell, Sun Prairie, chairman of the State Medical Society's Commission on Public Policy, summarized the attitude of the medical profession:

> To achieve the highest possible level of health care for all the citizens of Wisconsin, it is necessary that every person interested in and qualified for the study of medicine have that opportunity.

He cited the State Medical Society's active role in seeking support for Marquette:

> As you know, the State Medical Society of Wisconsin has given its energetic and full support to the recommendations of the Governor's Task Force on Medical Education. Part of this recommendation requires the rapid expansion of Marquette School of Medicine to permit the admission of at least 160 students each year. Obviously, this goal cannot be achieved if the school is unable to continue in operation for lack of funds.
>
> When the financial plight of Marquette School of Medicine reached the critical stage last July, the State Medical Society launched an intensive program to alert the people of Wisconsin to the health crisis that would follow the possible closing of that institution.
>
> Full and quarter page advertisements were published by the Society in the state's major daily newspapers calling for contributions to ease the immediate fiscal crisis at Marquette.
>
> Letters explaining the Marquette problem were sent to state officers, legislators, and leaders of business, industry and labor throughout Wisconsin.
>
> Publicity was given in the medical press to encourage support from Marquette medical alumni.
>
> News stories were developed through the state's media to explain that Marquette School of Medicine graduates currently practice in nearly 200 communities in Wisconsin.
>
> The Society entered a brief amicus curiae in support of the need to recognize Marquette School of Medicine as a major contributor to the public's health needs.
>
> We feel that the sum of these efforts has had considerable impact on the favorable actions of the Supreme Court, the public, and the Wisconsin

continued on page 71

OFFICERS OF MARQUETTE School of Medicine look on as Gov. Warren P. Knowles signs into law a bill which boosts the state tax on beer to provide financial assistance to the school and thus keep its doors open. Behind Governor Knowles are, from left, Louis Quarles, Milwaukee, medical school president; Ernest J. Philipp, Milwaukee, member of the Board of Trustees; and Dr. Gerald Kerrigan, Whitefish Bay, dean of the school. (Photo courtesy *Modison Copital Times*)

HIGH RISK RUBELLA EXPOSURE TO TEACHERS AND NURSES

The 1964–1965 rubella epidemic resulted in 20,000 defective babies. At the present time approximately 80% of all adults are immune to rubella. Nurses and school teachers have more exposure to rubella due to the contacts in their occupations. At the present time rubella immunization is not routinely recommended for postpubertal females *since pregnancy is a contraindication to immunization with live rubella virus.*

Since nurses and school teachers are a high-risk group as far as exposure to rubella is concerned, they should be tested for immunity to rubella with the hemagglutination–inhibition (HI) antibody determination. This test must be performed by a competent laboratory.

For the 20% who are susceptible to rubella, immunization with live virus should be considered. If immunization is undertaken, the patient must understand that it is imperative *that she not be pregnant nor shall become pregnant for the following two months.* She also should be cautioned that she may develop transient and self-limited adenopathy or arthralgia 2 to 4 weeks after immunization.

—JOHN EVRARD, MD

Legislative Hot Line

AFTER WORKING INTO THE LATE HOURS and attempting to consider as many bills as possible during the last remaining minutes, the Wisconsin Legislature recessed on Saturday, Nov. 15, until Jan. 5, 1970. The great majority of the bills introduced this session have not had final consideration as yet, but several key bills of concern to the State Medical Society have been passed. With the Legislature returning to Madison Jan. 5, it is important that all physicians be aware of the current status of some of the bills which have passed and those which will be considered further . . .

MEDICAL PRACTICE ACT . . . Both the Assembly and the Senate have passed Senate Bill 583 which was introduced at the request of the Society. This legislation, which is designed to update the Medical Practice Act and to help alleviate the physician shortage, now awaits the signature of the Governor. The revision is the first major attempt to completely update the medical licensing laws in several years. It was drafted by the State Medical Society's Ad Hoc Committee on the Medical Practice Act after consultation with several state agencies concerned with health care.

SCHOOL EXCUSES BY CHIROS . . . Chiropractic lost its bid to win legislative authority for school boards to accept a chiro's word to excuse pupils from classes. The chiros had attempted to attach their proposal to school legislation, but the move was opposed by the SMS on the basis that such action would substantially weaken the legislation and would not be in the best health interests of pupils.

HEARING AID LICENSURE . . . Assembly Bill 391 has passed both Houses of the Legislature with several amendments suggested by the Society. Among the items included were a provision requiring measurement of hearing before an aid can be sold and a requirement that an individual 16 years or under must have had a medical examination at least 90 days prior to the time that he is fitted with a hearing aid. Two Society objections were not met in this legislation which is now before the Governor for his signature. These were a recommendation that hearing aid dealers should be licensed under the auspices of the Medical Practice Act, since they are in effect an ancillary health group, and a suggestion that the funds to be collected under the proposal are not enough to allow a separate board to properly enforce the act.

CORONER SYSTEM . . . A Senate Joint Resolution, which calls for a change in the Wisconsin constitution, would permit a county or group of counties to establish a medical examiner system in lieu of the office of coroner. This legislation, which has passed the Senate and Assembly, was supported by SMS.

PSYCHOLOGY LICENSING LEGISLATION . . . was passed by both Houses of the Legislature, although opposed by the Society in its present form. The legislation, if signed by the Governor, will create an independent board to license psychologists.

MEASLES IMMUNIZATION . . . Voluntary measles immunization programs may be set up by the State Department of Health and Social Services under Bill 131, A. which has passed the Assembly. The bill will be taken up by the Senate in January. The Society has previously opposed mandatory plans for immunization, but has not objected to the program as it would be conducted under 131, A.

CHIROPRACTORS UNDER WORKMEN'S COMPENSATION AND TITLE XIX (MEDICAID) . . . The Assembly passed 97, A., which would provide that chiropractors can be paid for services under Title XIX (state-administered Medicaid), and 307, A., which would allow payment for such services under Workmen's Compensation. The Society opposes both bills. They are scheduled for Senate public hearing in January. Physicians should be aware of the position taken by the Department of Health, Education, and Welfare on the inclusion of chiropractic services under Title XIX. The HEW report, which should be made known to all legislators stated,

> "Chiropractic theory and practice," HEW concluded, "are not based upon the body of basic knowledge related to health, disease and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment.
>
> "Therefore, it is recommended that chiropractic service not be covered in the Medicare program."

Also, the Wisconsin Advisory Council on Workmen's Compensation, which includes representatives of organized labor, has opposed inclusion of chiropractic services under Workmen's Compensation.

IMPLIED CONSENT . . . Both the Senate and Assembly have passed different versions of a bill calling for tests for individuals suspected of driving while under the influence of alcohol. The Society has supported the principle of implied consent; however, it feels that such legislation should grant immunity to physicians who are performing the tests required. The bill now must either be passed in the form in which it was adopted by one of the Houses or be sent to a conference committee in an attempt to work out the differences.

OTHER BILLS . . . which the Society has followed and which will be considered in January are: eye safety protective devices in schools (251, S.), school bus operators' licenses (334, S.), state aid for out-patient dispensaries (347, S.), creation of a clinical laboratory personnel examining board (548, S.), establishment of a medical council in the Division of Motor Vehicles (318, A.), creation of a council on the sciences as an arm of the Legislature (933, A.), establishment of drug abuse and drug education programs (1068, A.), and licensing of dispensing opticians (469, S.).

MARQUETTE *continued from page 69*

Assembly and Senate in developing legislation to assure the continuation of this important school.

Directly or indirectly, every member of the State Medical Society contributed to the "Save Marquette" effort.

Knowles described the new law as "an occasion of tremendous importance to the health of Wisconsin's citizens and to the future of medical education of our state."

Under the law, the Marquette School of Medicine will submit its budget requests to the Governor and copies to the Coordinating Council for Higher Education. The Council will conduct a program analysis for programs supported in part by state funds, and the Legislative Audit Bureau will audit expenditures. A third of the members of the Board of Directors of the school are public appointees.

REMINDER!

Nov. 30–Dec. 3: AMA Clinical Session, Denver, Colo.

Dec. 6: "In-Depth" Teaching Program on The Role of Exercise in Heart Disease, University of Wisconsin and State Medical Society, Madison.

Dec. 11: Annual Meeting of The Medical Society of Milwaukee County, Holiday Inn, Milwaukee.

EDITORIAL

"Drug Turn On"—A Continuing Educational Program

Reflecting on the State Medical Society's "Drug Turn On" statewide TV series in its recent 7th Annual Work Week of Health, there are some positive actions that we physicians can take immediately to stem the growing menace of drug abuse.

The "coping-out"—unwillingness to face reality as it is—of parents and the older generation is frequently alluded to by young people as setting a very bad example and creating a credibility gap very difficult to bridge: a double standard.

While excessive use of alcohol and tobacco are most frequently cited as favorite escape mechanisms, one has but to stand at a busy pharmacist's elbow for an hour to get an overall view of how great a part hypnotics, sedatives, and tranquilizers play in modern society. Barbiturates and meprobamates, especially, are to be found in the top ten list of all drugs prescribed in the U.S. While these drugs serve a very valuable place in medical practice, perhaps the time has come when a closer clinical evaluation of the actual need of our individual patients for such drugs is in order.

One can hardly write routine admission orders for a newly hospitalized patient without being reminded of a p.r.n. order for a hypnotic and analgesic in addition to the traditional cathartic. The not-so-funny radio commercials selling composure ironically point to the legitimate "cop-out" from the disturbing events of everyday living. Parents taking tranquilizers, stimulants, and hypnotics in cyclic fashion are in a poor position to lecture their youngsters of the evils of marijuana.

We as physicians need to review our prescribing practices and perhaps spend more time explaining to the patient the psychosomatic effects of the anxieties and tensions of modern life. In the final analysis the only real successful escape from reality is the final "cop-out:" death.

Young people with drug use and drug abuse problems, actual or imagined, need objective professional advice without preaching. Every physician to be effective in this area needs to be brought continually up to date with the latest knowledge on marijuana, LSD, amphetamines, barbiturates, narcotics, and other commonly abused agents. Our State Medical Society could well coordinate the distribution of current and factual information and include the drug subject more often in our scientific programs.

More time spent on the problem of drug abuse in our medical school curriculum would certainly be appropriate. We are a medicine-conscious society and we as physicians must protect our patients from drug-induced disability wherever possible. Sir William Osler stated, "A desire to take medicine is, perhaps, the great feature that distinguishes man from other animals;" today's drugs are so much more complicated—and so far more effective—than those of Osler's days that one of our main responsibilities now is to have adequate knowledge of the adverse actions and interactions of the drugs we prescribe.

Today—not tomorrow—please review, recheck, and correct if necessary the safeguarding of narcotics and potentially dangerous drugs you now have in your custody. How effectively are you protecting your prescription pads from theft, your disposable syringes and needles from being reused illegally, and your many unsolicited drug samples from falling into nonprofessional hands?

Finally, we cannot permit our recent "Drug Turn On" program to become an isolated health education effort, nor do we intend to. Physicians are uniquely qualified to contribute knowledge on this great social problem that no other group is able to offer. Your State Medical Society, in cooperation with all interested groups and individuals, is committed to an all-out public education program on a continuing basis.

—ROBERT E. CALLAN, M.D.

WANTED: USED EXAMINING AND LAB EQUIPMENT

To the State Medical Society of Wisconsin:

On October 1, 1969, I became the Director of Health Services at Stout State University. This is the first time in the history of this institution that a full time student health physician has been on the staff. As you might well imagine, the facilities and equipment currently available allow me to only practice a very limited amount of medicine. I am in dire need of office examining and laboratory equipment.

The budget is limited, and it is an understatement, to say the least, that what I am presenting to you is a hardship case.

I am therefore inquiring whether such equipment, in good used condition, may be available from the physicians of Wisconsin, or medical institutions within the State. If this equipment could be obtained for the cost of transportation or for a very reasonable amount, I can assure you that the student body of this University would benefit greatly and be most appreciative.

Therefore, I am asking for help from your office to help me locate used examining and laboratory equipment.

Thanking you in advance, I remain

Sincerely,

Darrell L. Witt, M.D.
Stout State University
Menomonie, Wisconsin 54751

Secretaries Laird and Finch Visit Marshfield

The shortage of skilled medical personnel and the problems in transporting injured persons to hospitals were major points discussed by two top-ranking members of President Nixon's cabinet when they visited the Marshfield Clinic in Marshfield Oct. 26.

Secretary of Defense, Melvin R. Laird, who is a Marshfield resident and former Congressman for the central Wisconsin area, brought Secretary of Health, Education, and Welfare, Robert Finch, to Wisconsin as his guest. They addressed a Clinic and Clinic Foundation audience.

Secretary Laird credited the Marshfield Clinic as the originating site for the national pilot project utilizing helicopters in this country to transport injured persons to hospitals. He pointed out that the three pilot projects now underway in the nation are another example of the close cooperation between Defense and the Department of Health, Education, and Welfare.

We plan to draw upon our battlefield experience in the use of helicopters for the speedy evacuation of the wounded to places where care is available. By use of the helicopter we have saved many from death and from disability in Vietnam, he noted.

If present trends continue, Secretary Laird continued, more than 56,000 Americans are expected to be killed and two million to be injured on our highways this year.

In order to reduce the frightful toll of death and disability on the highway, Secretary Laird said the Department of Defense has joined with the Department of Health, Education, and Welfare and other Federal agencies to form a committee that is now studying means of making the helicopter a flying ambulance here at home as it is in Vietnam.

Secretary Finch in discussing the shortage of medical personnel, noted that 35 to 38 percent of the doctors licensed to practice last year were trained abroad and that too few new doctors go into general practice.

TWO TOP-RANKING MEMBERS of President Nixon's cabinet recently visited the Marshfield Clinic at Marshfield. They are shown above, from left: Melvin R. Laird, Secretary of Defense; Dr. Ben R. Lawton, Clinic President; Dr. Russell F. Lewis, Clinic Medical Director; and Robert Finch, Secretary of Health, Education, and Welfare.

He expressed the opinion that some form of "obligated service" for medical graduates may become necessary to provide medical service in areas where it is most needed.

Subsidization of the student, the school, or both may be in the future, he observed, and some separation of medical research and medical education may aid in solving the problem, Secretary Finch noted.

"With 100 medical schools graduating only 100 doctors a year, we are playing catch-up ball," Secretary Finch continued. He said that 24 new medical schools are needed, but doesn't see them coming. In meeting with medical school deans he is recommending a 10 to 15 percent increase in their freshman classes and studying subsidization as a means of helping them do so.

Secretary Laird used the Marshfield Clinic meeting to disclose that the Defense Department is formulating a plan to open up opportunities for placement in civilian health professions for those who have acquired medical training and skills in service.

Some 30–35,000 military personnel who are qualified medical technicians or technologists — trained and experienced during their period of military service—reenter civilian life each year, the Secretary said.

"By bringing together in some way these trained men and the jobs in civilian life in the field of health services for which they are qualified, I believe we can help to improve health care and avoid a waste of skill and training," Secretary Laird added.

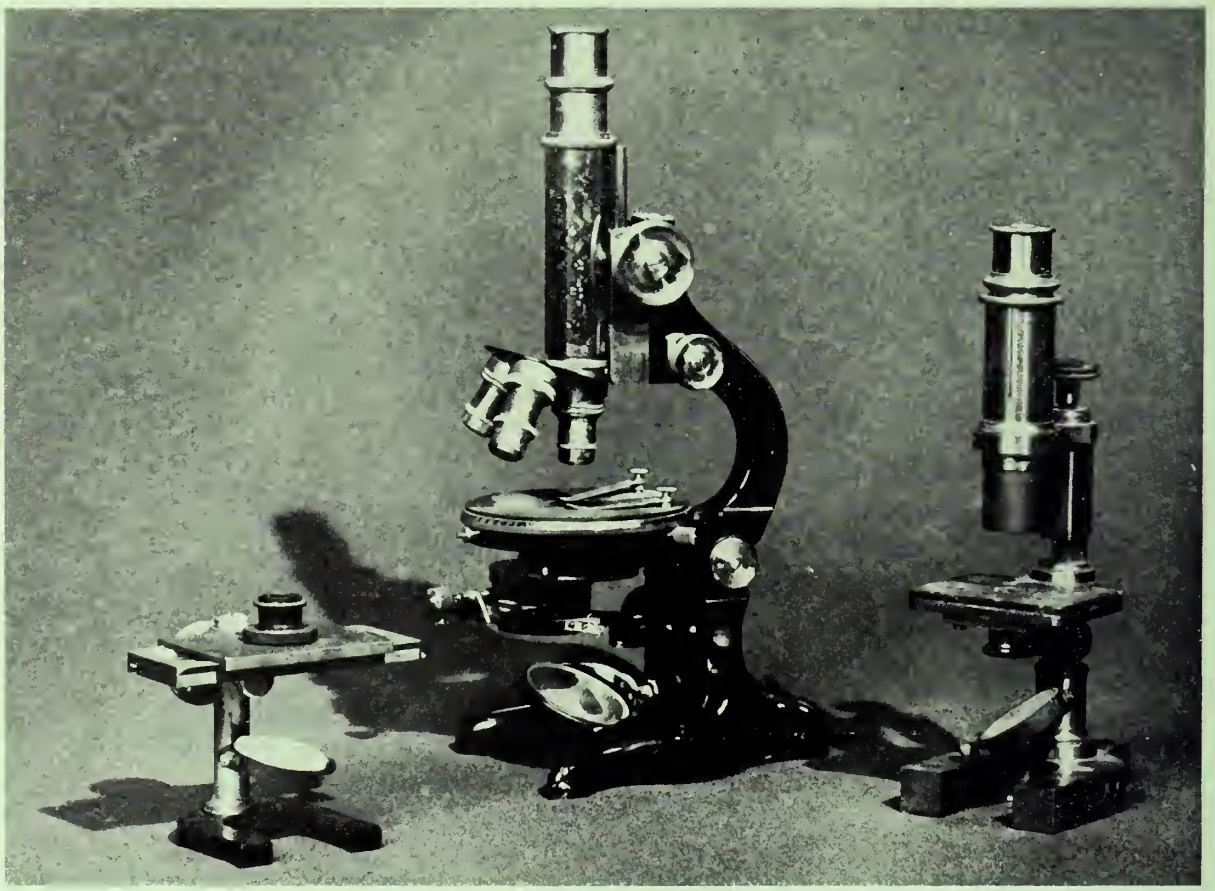
He said he has directed the Assistant Secretary of Defense for Manpower, Roger Kelley, to develop a plan that will maximize the opportunities to utilize in civilian life the valuable medical skills possessed by many servicemen.

This is but one of several steps which the Defense Department is taking to make more widely available the special know-how that it possesses in the field of health care. We have a study underway called the New Generation of Military Hospitals which is designed to improve service and reduce cost in the operation of such institutions. The results of this study will, Secretary Laird feels, have an important impact on hospitals of the future, civilian as well as military, leading to better health facilities in the future for the entire nation.

WANTED FOR DISPLAY

OLD TIME MICROSCOPES

With the cooperation of the Wisconsin Society of Pathologists we are developing an exhibit



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NEWS HIGHLIGHTS

Dr. George V. Murphy, President, WAGP

Dr. George V. Murphy,* South Milwaukee, was elected president-elect of the Wisconsin Academy of General Practice at its 21st annual meeting in Madison, Oct. 8–9.

Doctor Murphy will take office as president in 1970, succeeding Dr. A. J. Sanfelippo* of Milwaukee.

Dr. Nicholas F. Damiano,* Hales Corners, was elected secretary–treasurer. Other officers elected were Dr. R. W. Shropshire,* Madison, speaker of the Congress of Delegates; Dr. M. E. Wegner,* St. Croix Falls, vice-speaker; Dr. Donald J. Heyrman,* Menomonee Falls, Dr. Paul E. Wainscott,* Menasha, Dr. T. C. Fox,* Antigo, Dr. H. C. Rahr,* Luxemburg, and Dr. William Hein* of Monroe, members of the Board of Directors.

Dr. Joseph S. Devitt,* Milwaukee, was reelected as delegate to the American Academy of General Practice. Dr. Albert H. Stahmer,* Wausau, was elected alternate delegate.

The organizations Congress of Delegates approved a resolution urging the State Legislature to appropriate funds for the continued operation of the Marquette School of Medicine, with the stipulation that a specific amount of the financial support be used for creating a Department of Family Medicine at the school to "insure a continued production of family physicians for the State of Wisconsin." The resolution also recommended that the tuition for residents of the State of Wisconsin be the same at both Marquette and the University of Wisconsin Medical School. Currently the tuition at Wisconsin's medical school is $750 a year. At Marquette it is $1,750.

Another resolution urged the State Medical Society of Wisconsin to spearhead a movement in Wisconsin to set up panels to arbitrate malpractice claims. In other states where these panels have been established, malpractice claims have diminished.

Another resolution called attention to the recent decreases in welfare payments in the State of Wisconsin and urged the State Legislature to restore welfare payments to a more equitable level.

Two other resolutions commended the efforts of the University of Wisconsin Medical School and its plans for a Family Medicine Program in the school, and called on the State Legislature to seek solutions to increase internship and residency programs in this state and to increase the number of physicians eligible for these postgraduate programs.

The Academy has a membership of 850 family physicians in Wisconsin.

Radiologists Elect

Dr. Wayne M. Rounds* of Madison was installed as the new president of the Wisconsin Radiological Society at the group's annual meeting in September at Lake Geneva.

Other officers are: president-elect —Dr. Harold F. Ibach,* Milwaukee; vice-president—Dr. Leslie E. Jones,* Fond du Lac; and secretary-treasurer, Dr. Robert F. Douglas,* Neenah.

Dr. Howard G. Bayley,* Beaver Dam, was elected as a councilor to the American College of Radiology. Dr. Loren Hart* of Green Bay is the other councilor.

Dr. R. J. Fogle Heads Otolaryngologists

Dr. Richard J. Fogle* of Racine is the new president of the Wisconsin Otolaryngological Society. Vice-president is Dr. William C. Randolph* of Manitowoc and secretary-treasurer is Dr. Harold E. Manhart* of Madison.

PHYSICIAN BRIEFS

Dr. Theresa Cachuela

. . . Winnipeg, Canada, recently became associated with Dr. C. F. Meyer* at the Independence Clinic, Independence. Doctor Cachuela, a surgeon, is qualified by the American Board of Surgery and is now on the medical staff of Tri-County Memorial Hospital in Whitehall.

Dr. Harry Waisman

. . . of the University of Wisconsin Medical Center, Madison, has been selected by the American Academy of Pediatrics to serve as a Head Start consultant in Wisconsin.

Dr. Edward W. Walters

. . . Zanesville, Ohio, recently joined the staff of the Marshfield Clinic. Doctor Walters had his early education at Ohio University, graduating with a master's degree in Science in 1953 and from 1952 to 1955 was associated with the Children's Hospital Research Foundation, Cincinnati, Ohio. He graduated from the University of Cincinnati Medical School in 1959 and interned at George Washington University Hospital, Washington, D. C. His residency in internal medicine and a fellowship in infectious diseases was taken at George Washington Medical Division of the Washington, D. C. General Hospital. He was on the staff of the Veterans Hospital, Richmond, Va. and was assistant professor of medicine at The Medical College of Virginia, Richmond. Prior to joining the Marshfield Clinic staff, he had been assistant professor of laboratory medicine and assistant professor of medicine at the University of Cincinnati College of Medicine.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dr. David F. Sweet

. . . has joined the Sheboygan Clinic staff under a locum tenens arrangement until June 1970. He will then begin a residency training program in ophthalmology at Marquette University. Doctor Sweet graduated from the University of Minnesota Medical School and served his internship at San Bernardino County General Hospital, Calif. He has been granted staff privileges at St. Nicholas and Sheboygan Memorial hospitals.

Dr. Oscar F. Foseid*

. . . Madison, recently was featured as "Know Your Madisonian" in the WISCONSIN STATE JOURNAL. He graduated from the University of Wisconsin School of Commerce in 1931 and from the Washington University Medical School, St. Louis, in 1939. His residency and internship were taken at St. Paul, Minn. He served in World War II from 1943 to 1947 and then went into surgical residency at the University finishing in 1955. He joined the Jackson Clinic, Madison, in 1955 and has been there ever since. Doctor Foseid has been active in community affairs and has been the medical consultant for the East High School football team since 1951 and has missed only one home game.

Dr. William Lipman*

. . . Kenosha, recently was honored by the Alumni Association of the University of Wisconsin. He is one of eight alumni who received the association's Spark Plug award for their leadership in alumni activities. Doctor Lipman earned his medical degree from Rush medical school, Chicago, but did his premedical studies at the University of Wisconsin.

Dr. Irvin Reid

. . . Wauwatosa, on October 1 became the new president of the Kiwanis Club of Central Wauwatosa.

Internist Group Honors Dr. Karl Doege

The Wisconsin Society of Internal Medicine paid tribute to one of its founders during the two-day annual meeting of the Society in Wisconsin Dells Sept. 12–13.

The First Karl H. Doege Recognition Lectureship was presented by Dr. Burton A. Waisbren,* assistant clinical professor of medicine at the Marquette School of Medicine, Milwaukee. His paper was entitled, "The Challenge of Critical Care."

Dr. Karl H. Doege,* veteran member of the Marshfield Clinic's department of internal medicine, also was presented with a recognition plaque by Dr. James W. Manier,* Marshfield, retiring president of the WSIM and a representative of Doctor Doege's colleagues at the Marshfield Clinic.

Doctor Doege was a founder and second president (1957) of the WSIM and is also a past president of the State Medical Society of Wisconsin (1949–1950). He will celebate his 50th year with the Marshfield Clinic this December. (Photo courtesy the Marshfield Clinic)

Dr. Karl H. Doege

Cig Machines Go at Green Bay

St. Vincent and Bellin Memorial Hospitals in Green Bay on October 1 discontinued cigarette sales in the hospitals.

Society Helps with Newborn Institutes

Seven Newborn Institutes have been arranged by the State Medical Society's Division on Maternal and Child Welfare and the State Division of Health for this fall and next spring.

Practicing physicians interested in the care of the newborn are urged to attend one of these sessions when it is held in their area. Three hours of credit for the Wisconsin Academy of General Practice requirements will be given to each GP attending.

Three institutes have already been held: Oct. 15 at St. Agnes Hospital in Fond du Lac, Oct. 16 at St. Vincent's Hospital in Green Bay, and Nov. 6 at St. Francis Hospital in La Crosse.

The remaining schedule is as follows: Feb. 12, Marquette University School of Nursing, Milwaukee; May 6, Duluth, Minn.; May 7, St. Joseph's Hospital, River Falls; and May 19, St. Joseph's Hospital, Marshfield.

The Faculty is composed of outstanding people in their fields: Drs. Stanley Graven,* John Grausz, Gertrude Howe,* Michael L. McCann, Gerald Staub, and Richard Zackman.

Subjects covered include: Infant Mortality and Morbidity, The Newborn with Respiratory Distress (approaches to differential diagnosis and treatment), Hyperbilirubinemia, and The High-Risk Infant and Hypoglycemia. There also will be group case discussions.

Anesthesiologists Elect

At the September annual meeting of the Wisconsin Society of Anesthesiologists held at Lake Geneva, the following officers were elected: president—Dr. J. N. Pollin, Fond du Lac; president-elect, Dr. Robert E. Holzgrafe,* Waukesha; secretary—Dr. Ruth Stoerker,* Milwaukee; and treasurer—Dr. John Kelble,* Milwaukee.

Dr. Sivertson, New Assistant Dean, UW

Dr. Sigurd E. Sivertson,* Madison, on Sept. 30 was named assistant dean at the University of Wisconsin Medical School.

A member of the medical school faculty since July 1, 1968, Doctor Sivertson previously had been in private practice in LaCrosse since 1955. During his first year at Wisconsin as a clinical assistant professor of medicine, he has served as director of the medical school's preceptor program and as associate chairman of the postgraduate medical education department.

Dr. Sivertson

Doctor Sivertson is a native of La Crosse and received his BS degree from Wisconsin before earning his MD there in 1947. After interning at St. Luke's Hospital, Duluth, he was a resident in internal medicine at La Crosse Lutheran Hospital. He served at an army evacuation hospital in Korea from 1949–1951 and returned to the Mayo Foundation, Rochester, Minn., where he was a fellow in internal medicine for three years. He also earned his MS from the University of Minnesota in 1955.

For the next 13 years he practiced internal medicine at the Gundesen Clinic and La Crosse Lutheran Hospital and served those organizations as director of medical education and research.

On August 1, Doctor Sivertson was appointed assistant coordinator for the Wisconsin Regional Medical Program. He also is a board member of the Wisconsin Medical Alumni Association and served as the 1947 class representative.

Plastic Surgeons Elect

At the recent annual meeting of the Wisconsin Society of Plastic Surgeons, the following officers were elected: president—Dr. Sidney K. Wynn,* vice-president—Dr. George J. Korkos,* and secretary–treasurer—Dr. Wilbert Wiviott,* all of Milwaukee.

Dr. Theodor Habel

. . . recently joined the medical staff of Antigo Medical Center. He graduated from the University of Wisconsin Medical School and served a rotating internship at Iowa Lutheran hospital, Des Moines. Doctor Habel recently returned from two years service with the United States Public Health Service in the Philippines.

Dr. Robert C. Hickey

. . . former chairman of the Surgery Department at the University of Wisconsin Medical Centive vice-president and director of the University of Texas M.D. ter, recently was named execu-Anderson Hospital and Tumor Institute at Houston, Tex. Doctor Hickey was elected a governor of the American College of Surgeons last year and has been awarded a bronze medal from the American Cancer Society for his work in cancer control. Prior to his recent appointment, Doctor Hickey was deputy director of the cancer institute and hospital.

HOW WELL HAVE YOU PLANNED THE FINANCIAL ASPECTS OF YOUR RETIREMENT?

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Dr. Frank Drew*

. . . Milwaukee, former president of the State Medical Society, has resigned from the State Board of Health and Social Services. He cited pressures of his medical practice in a letter of resignation. Doctor Drew's term expires May 1, 1971. He was appointed to the board when it was reorganized in 1967 and previously had been a member of the old state board of health.

Drs. James N. Moore*

. . . and H. P. G. Barnes,* Madison, have opened the new Odana Medical Clinic in partnership. The new clinic is an amalgamation of the former Hill Farm Family Clinic.

Dr. G. Daniel Miller*

. . . chief of anesthesia at Oconomowoc Memorial Hospital, is heading the professional division of the Oconomowoc Area United Fund drive. Doctor Miller is president-elect of the Waukesha County Medical Society. He serves on the State Medical Society's Committee on Cancer and has been active in American Cancer Society programs.

Dr. Frederik A. Karsten*

. . . Horicon, has been elected president of the Dodge County Unit of the American Cancer Society for the 1969–1970 year. In accepting the position Doctor Karsten cited as one reason for serving the fact that his grandmother, Mrs. Fred Clausen, and Dr. William D. Stovall* are frequently referred to as the "co-founders of the Wisconsin Division of the American Cancer Society."

Dr. J. P. Keepman*

. . . recently was elected president of the medical staff of Methodist Hospital, Madison. Other officers elected were: Dr. Howard W. Mahaffey,* vice-president; and Dr. Louis F. Warrick,* secretary-treasurer, all of Madison.

Wisconsin Surgeons New ACS Fellows

Twenty-seven Wisconsin surgeons were among the 1,523 surgeons inducted as new Fellows (members) of the American College of Surgeons at the group's annual clinical congress Oct. 6–10 in San Francisco.

They are: Drs. Earl B. Kitzerow,* Appleton; Robert N. Benneyan,* Fond du Lac; Robert J. Nickels,* Hartford; Gregory H. Maharias* and James T. Murphy,* La Crosse; Klaus D. Backwinkel,* John F. Batson,* James M. Huffer,* Paul O. Madsen,* Harold E. Manhart,* Tadeusz A. Schimanek,* and David T. Uehling,* Madison; Robert J. DeWitt,* Marinette; Jerry Medaris Hardacre,* Marshfield; Ingrid E. Jurevics,* H. Myron Kauffman, Jr.,* George J. Korkos,* Donald M. Levy,* Abdallah G. Melkonian,* Marvin Poll,* Richard E. Rodgers,* and Knud C. Stobbe,* Milwaukee; John O. Simenstad,* Osceola; Richard A. Eckberg,* Stevens Point; Jack A. Peterson* and John W. Bunke,* Waukesha; and Konstantine S. George,* West Allis.

Helicopter Ambo Demonstrated

A practical demonstration of the coming use of helicopters in pickup and delivery of emergency victims to hospitals was held recently in the parking lot of Elmbrook Memorial Hospital, Brookfield.

Dr. Gaenslen Heads Orthopedists

Dr. Frederick Gaenslen* of Milwaukee, was recently elected president of the Wisconsin Orthopaedic Society. Dr. Jerome W. House* of Milwaukee is the secretary-treasurer.

Hustisford Hospital Closes

After 35 years of continuous operation, the Hustisford Hospital closed its doors Oct. 31.

CONTRIBUTIONS—CES FOUNDATION
September 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for September 1969:

Nonrestricted

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E. J. Nordby, MD	Memorial: Cpl. Charles R. LeBosquet
E. J. Nordby, MD	Memorial: Wm. Edwards, MD
Robert B. Murphy	Memorial: Mrs. Paul Geisler
Dr. and Mrs. E. J. Nordby	Memorial: Robert E. Burns, MD
C. H. Crownhart	Memorial: Robert E. Burns, MD
Robert B. Murphy	Memorial: Robert E. Burns, MD
Dr. and Mrs. Gordon J. Schulz	Memorial: Stella Frack
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Harold J. Hoops, Jr., MD	Memorial: Mrs. E. G. Nadeau
State Medical Society	Memorial: Robert A. Scheidt, MD
State Medical Society	Memorial: Wilmer C. Edwards, MD
State Medical Society	Memorial: Mark A. Bailey, MD
State Medical Society	Memorial: Robert E. Burns, MD
State Medical Society	Memorial: Mrs. Clifton Bates

continued on next page

Dr. Timothy K. Henke

. . . and Dr. Larry A. Lindesmith recently joined the staff of the Gundersen Clinic, Ltd., and Lutheran Hospital, La Crosse. Doctor Henke graduated from the University of Wisconsin Medical School and served a rotating internship at Rhode Island Hospital, Providence. He returned to the University of Wisconsin Medical Center for his neurology residency and completed it in 1967. Prior to joining the Gundersen Clinic, he served as chief of the department of neurology at Carswell Air Force Base Hospital. Doctor Lindesmith received his medical degree from the Bowman Gray School of Medicine, Winston–Salem, N. C. He served his internship at the University of Chicago hospitals and clinics and did his residency at the University of Colorado Medical Center, Denver. He completed a fellowship in pulmonary disease there and at Webb–Waring Institute for Medical Research from 1966 to 1967. He entered the United States Army and served at Madigan General Hospital, Tacoma, Wash., where he was assistant chief in pulmonary disease. He received an achievement award from the Army for his role in establishing the pulmonary function laboratory at Madigan General Hospital in Tacoma.

FOUNDATION CONTRIBUTIONS *continued*

Danforth Student Loan Fund

Mrs. Quincy H. Danforth ---------- Contribution

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD ---------- Contribution

Barbara P. Sargent Nursing Scholarship Fund

Earl R. Thayer ---------- Contribution
Dr. and Mrs. Joseph Jauquet ---------- Contribution
Dr. and Mrs. Wm. J. Smollen ---------- Contribution
Mrs. Eunice S. Meier ---------- Contribution
Dr. and Mrs. Jack J. Levin ---------- Contribution
Rosepha Ambrose ---------- Contribution
Ada Bauman ---------- Contribution
Dr. and Mrs. Wm. T. Brodhead ---------- Contribution
Dr. and Mrs. Bernard S. Scaeffer ---------- Contribution
Olive L. Cunningham ---------- Contribution
Edith Hope Pearson ---------- Contribution
Dr. and Mrs. Thos. W. Tormey, Jr. ---------- Contribution
Mrs. Norman M. Clausen ---------- Contribution
Mr. and Mrs. G. W. Chesemore ---------- Contribution
Dr. and Mrs. John Satory ---------- Contribution
Mrs. Delores M. Fisher ---------- Contribution
Mrs. A. W. Hammond ---------- Contribution
Dr. and Mrs. Frederick H. Wolf ---------- Contribution
Dr. and Mrs. Gordon J. Schulz ---------- Contribution
Mrs. L. O. Simenstad ---------- Contribution
Dr. and Mrs. John J. Foley ---------- Contribution
Thomas E. Zabors, MD ---------- Contribution
Dr. and Mrs. Loren J. Driscoll ---------- Contribution
Mrs. Genevieve Picard ---------- Contribution
Dr. and Mrs. Victor J. Kozina ---------- Contribution
Mrs. Myrtle M. Northey ---------- Contribution
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Dr and Mrs. George Kordiyak ---------- Contribution
Dr. and Mrs. Richard E. Zellmer ---------- Contribution
Dr. and Mrs. Clifford R. Schneider ---------- Contribution
Dr. and Mrs. Robert Johnston ---------- Contribution
Dr. and Mrs. William Ford ---------- Contribution
Dr. and Mrs. Joseph G. Gramling, Jr. ---------- Contribution
Waukesha County Medical Society Auxiliary ---------- Contribution
Pierce, St. Croix County Medical Society Auxiliary ---------- Contribution
Grant County Women's Medical Auxiliary ---------- Contribution
Sheboygan County Medical Society Auxiliary ---------- Contribution
Woman's Auxiliary to the Winnebago County Medical Society ---------- Contribution
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Louis H. Kretchmar, MD ---------- Contribution
Mrs. J. F. Henkin ---------- Contribution
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Mrs. Betty Sargent Hammack ---------- Contribution
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Marilyn S. Hurwitz ---------- Contribution
Estelle B. Kilkenny ---------- Contribution
Ruth S. Scrivner ---------- Contribution
Dr. and Mrs. Robert A. Straughn ---------- Contribution
Fred G. Gaenslen, MD ---------- Contribution

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF OCTOBER 1969

1 Teachers Group Tour, Cooperative Education Service Association (EDP Operation)
2 Board of Directors, Wisconsin Association of Professions
6 Wisconsin Work Week of Health: "The Drug Turn-on" (Eau Claire—TV Channel 13)
7 Wisconsin Work Week of Health: "The Drug Turn-on" (Madison—TV Channel 27 and Wausau—TV Channel 9)
7 Madison General Hospital Surgical Staff
7 Madison Anesthes. Society
7 Madison Anesthesiology Society
7 Dane County Medical Society Board of Trustees
8 Wisconsin Work Week of Health: "The Drug Turn-on" (Green Bay—TV Channel 5 and Escanaba—TV Channel 3)
9 Wisconsin Work Week of Health: "The Drug Turn-on" (Milwaukee—TV Channel 4, Duluth—TV Channel 10 and La Crosse—TV Channel 8)
9 Madison Academy of Internal Medicine
14 McFarland High School Student Tour (EDP Operation)
14 Dane County Medical Society Annual Meeting
16 Executive Committee, SMS Commission on Medical Care Plans (Lake Delton)
18 Annual Meeting, Wisconsin Association of Professions
18 Exec. Com. of SMS Council
19 SMS Division on Nervous and Mental Diseases
20 American Board of Internal Medicine Exam
21 American Board of Internal Medicine Exam
22 State Pharmacy Board Exam
22 Planning Committee, Wisconsin Regional Medical Program
27 Dane County Medical Society Utilization Review Plan
28 Faculty Committee and Junior Students, University of Wisconsin Medical School
29 SMS Ad Hoc Committee on Medical Practice Act
29 Conference on Radiation Therapy Center
30 State Board of Medical Examiners (Reciprocity Exams)
30 Editorial Committee, SMS Division on School Health

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

RETIRED PHYSICIANS HONORED—Dr. P. G. Spelbring (left), retired EENT specialist, and Dr. H. C. Huston (right), retired radiologist, recently were recipients of awards at a Luther Hospital staff dinner party. With them above is the dinner speaker, Dr. Frederick N. Elliott, general director of Mount Sinai Hospital, Chicago, and an assistant director of the American Hospital Association. (Photo courtesy *Eau Claire Leader*)

Dr. Kuzma Resigns Pathology Post

Dr. George T. Hensley* recently was named acting director of the department of pathology and laboratories at Milwaukee County General Hospital.

He fills the post left vacant on Sept. 1 by the resignation of Dr. Joseph F. Kuzma* until a permanent appointment is made.

Doctor Kuzma also gave up his position as chairman of the department of pathology at Marquette School of Medicine, Milwaukee.

Doctor Kuzma will continue as a member of the faculty and will remain on the attending staff at the hospital.

Dr. Chesley P. Erwin* is serving as acting chairman of the pathology department at Marquette.

Doctor Hensley has been on the staff of Milwaukee County Hospital for about five years.

Marshfield Doctor to Head Clinic Unit

Dr. G. Stanley Custer* of the Marshfield Clinic has been named president-elect of the American Association of Medical Clinics. His presidency will start in 1971. He serves as a first vice-president until then.

Serving as president of the Association is Dr. Leonard L. Loshin of the Cleveland Clinic.

The Marshfield Clinic is one of the charter members of the AAMC which represents all the major medical clinics in the United States. Doctor Custer is a past president of the Marshfield Clinic.

FIRST BOARD EXAMINATIONS SET FOR FAMILY PRACTICE

The American Board of Family Practice has announced that it will give its *first* examination for certification in various centers throughout the United States.

The examination will be over a two-day period on Feb. 28–Mar. 1, 1970.

Information regarding the examination and eligibility for the examination can be obtained by writing: Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

WISCONSIN SOCIETY OF INTERNAL MEDICINE—Distinguished members of the WSIM got together with their national president for this picture at the recent annual meeting and scientific program of the society. From left to right they are: Dr. Herbert W. Pohle,* Milwaukee, ex-officio Council member; Dr. John M. Irvin,* Monroe, secretary–treasurer; Dr. Addis C. Costello,* Milwaukee, president-elect; Dr. Clyde C. Green, Jr., San Francisco, ASIM president; Dr. George R. Barry,* Monroe, WSIM president; Dr. James W. Manier,* Marshfield, immediate past president of WSIM; and Dr. Robert F. Madden,* Milwaukee, Council member.

Dr. Liebow Visiting Professor

Dr. Averill A. Liebow will be visiting professor for the Milwaukee Academy of Medicine Dec. 8 through Dec. 10. He is professor and chairman of the Department of Pathology, University of California, San Diego.

"Wegner's Granulomatosis and Allied Conditions" will be the title of Doctor Liebow's lecture at the Academy dinner meeting Dec. 9 at the University Club of Milwaukee.

Dr. Herzberger to Continue on Monroe Clinic Staff

Dr. Eugene E. Herzberger,* a neurosurgeon who recently announced that he would begin private practice in Madison, has changed his plans and will remain on the staff of The Monroe Clinic where he has practiced since 1960.

UNITED STATES PHARMACOPEIAL CONVENTION ANNOUNCEMENT AND REQUEST FOR DELEGATES 1970 DECENNIAL MEETING

In 1970, The United States Pharmacopeial Convention will open its decennial meeting. In addition to this meeting which is scheduled on April 8–10 at the Shoreham Hotel in Washington, D. C., on April 9, a special program will be presented honoring the 150th anniversary of the founding of The United States Pharmacopeia.

The second and final call for delegates to the decennial meeting was recently mailed to all organizations entitled to representation. The United States Pharmacopeia is the only national organization representing both the pharmacy and medical professions and its member organizations include state associations and societies of medicine and pharmacy, pharmacy and medical schools, various branches of the federal government, and national medical and pharmacy organizations.

Those bodies that are entitled to representation at the 1970 decennial meeting have been given notice of this meeting and have been requested to appoint a delegate and an alternate delegate.

Not only will this meeting be of special interest because of the sesquicentennial celebration but also it is expected that delegates will be giving new guidance and direction to U.S.P. programs. Delegates also will select a new Committee of Revision for the 1970–1980 decade and a new Board of Trustees to carry out these programs.—THE UNITED STATES PHARMACOPEIAL CONVENTION, INC., 4630 Montgomery Ave., Bethesda, Md. 20014; tel. 301/657–8317.

Dr. Joven L. Raneses*

. . . Madison, recently became associated with Dr. Lloyd S. Kellogg* in the practice of medicine in Oregon. Doctor Raneses graduated from the Manila Central University School of Medicine and received internship training at Chicago and Winnetka, Ill. He has served as a staff physician for the State of Wisconsin and the Veterans Administration Hospital in Tomah and is on the staffs of Methodist, Madison General, and St. Mary's hospitals, Madison. He is also a medical consultant at the Colonial Manor Nursing Home in Madison.

Dr. Martin C. Havel

. . . recently opened his medical office in the Odana Medical Center, Madison. He graduated from the University of Minnesota Medical School and recently completed his residency in obstetrics and gynecology at University Hospitals in Madison. He served two years as a medical officer in the United States Air Force and had practiced at Pine River, Minn.

Dr. Mark T. O'Meara*

. . . La Crosse surgeon, has been elected president of the newly merged Skemp–Grandview Clinic which began operations with 16 doctors on Oct. 1.

Other officers elected are: Dr. John T. Skemp,* vice-president; Dr. R. L. Gilbert,* secretary-treasurer.

Dr. Frederick C. Skemp* is president of the clinic building corporation while Dr. J. B. Durst* is the secretary-treasurer.

Julius Wetsch, manager of the Grandview Clinic, continues as manager of the combined clinic.

Dr. Frederick G. Hidde*

. . . Sheboygan, recently was elected to a third term as president of the Sheboygan County Unit, American Cancer Society, at the organization's annual meeting.

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WPS . . . The Doctor's Plan of the State Medical Society of Wisconsin

Dr. Etheldred Schafer

Dr. Etheldred Schafer*

. . . formerly of the Jackson Clinic in Madison, is the new staff pathologist and director of clinical laboratories at St. Mary's Hospital in Rhinelander. She fills the vacancy created when Dr. Murray A. Litton* left in September to accept a staff appointment in a Berne, Switzerland, hospital. (Photo courtesy of Rhinelander Daily News)

Dr. Kim P. Stien

. . . recently became associated in the practice of medicine with Drs. F. E. Gehin* and J. R. Erickson* in Stevens Point. He graduated from the University of Wisconsin Medical School and interned at Milwaukee County General Hospital. He was a captain in the United States Medical Corps and was awarded the Army Commendation Medal for meritorious service.

Dr. N. O. Calloway*

. . . Madison, recently was featured as "Know Your Madisonian" in the WISCONSIN STATE JOURNAL. Doctor Calloway, who has published more than 70 papers in chemistry, clinical medicine, and geriatrics, taught medicine at the University of Illinois and taught pharmacology at the University of Chicago. Doctor Calloway was on the staff of the Veterans Administration Hospital in Tomah and in 1966 began a private practice in Madison. He is on the staff of the Madison General Hospital and has received awards from conservation groups such as the National Wildlife Federation.

Dr. J. Michael Hartigan

. . . recently became associated with the Gundersen Clinic, Ltd. and Lutheran Hospital, La Crosse. Doctor Hartigan graduated from the State University of New York, Upstate Medical Center, Syracuse, and served as pediatric intern and pediatric resident from 1963 to 1966 in Columbus Children's Hospital and Ohio State University Hospital. Prior to serving two years in the Air Force, Minot, N. D., he was chief resident of pediatrics and clinical instructor in the department of pediatrics, Ohio State College of Medicine.

Dr. Josef Vosmek

. . . Park Falls, recently joined the staff of the Murphy–Eyvindsson Clinic in Park Falls. He graduated from the University of Wisconisn Medical School and served his internship at St. Luke's Hospital. From 1965 to 1967, he was with the United States Health Service in New Mexico and from 1967 to 1969 he served with the American Lutheran Mission in Ethiopia.

Dr. F. L. Schaefer*

. . . Neenah obstetrician and gynecologist and a University of Wisconsin instructor at Madison, was named president of the Wisconsin Division of the American Cancer Society during its annual meeting in mid-October at the Pioneer Inn, Oshkosh. He succeeds Dr. John K. Scott* of Madison.

Other officers elected are: Dr. Stanley L. Inhorn,* Madison, first vice-president; Mrs. James D. Swan, Elkhorn, second vice-president; J. Kenneth Conlin, Madison, treasurer; and Mrs. Donald Morrissey, Appleton, chairman of the executive committee.

The Rev. Perry H. Saito, Eau Claire, continues as chairman of the board of directors with Thomas S. Harvey, Shawano, vice-chairman.

Dr. Donald J. Kuban*

. . . Milwaukee, recently attended the annual joint meeting of the College of American Pathologists and American Society of Clinical Pathologists in Chicago. Doctor Kuban, an immunopathologist who has pioneered in tissue typing of recipients and donors for the metropolitan organ transplant program, was invited to teach at the meeting by Dr. Paul I. Terasaki of Los Angeles.

Dr. George E. Batayias*

. . . Waukesha, recently was appointed chief pathologist and director of laboratories at St. Luke's Hospital in Milwaukee. Doctor Batayias has been associate pathologist at St. Luke's since 1967.

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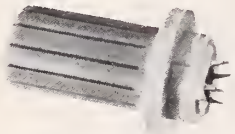

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF OCTOBER 7, 1969

NEW MEMBERS

Aaberg, Thomas M., 8700 West Wisconsin Ave., Milwaukee 53226
Adamkiewicz, Joseph J., Jr., 161 West Wisconsin Ave., Milwaukee 53203
Baker, Frederick Clark, 2900 West Oklahoma Ave., Milwaukee 53215
Block, Robert T., 900 South Webster Ave., Green Bay 54301
Foster, Lawrence L., 910 Elm Grove Rd., Elm Grove 53122
Jacobson, Mitchell M., 8700 West Wisconsin Ave., Milwaukee 53226
Kallas, Gerald J., 2320 North Lake Dr., Milwaukee 53211
Kidder, Thomas M., 3937 West Good Hope Rd., Milwaukee 53209
Redlin, Thomas A., 627 Cumberland Dr., Waukesha 53186
Schaefer, Kent C., 4720 Lincrest Dr., Brookfield 53005
Tibbetts, Jay Jeremy, 1551 Dousman St., Green Bay 54303
Vondrell, John J., 8700 West Wisconsin Ave., Milwaukee 53226

REINSTATED

Geiger, Sara G., 1028 East Juneau Ave., Milwaukee 53202

CHANGES OF ADDRESS

Ali, Masroor, Beaver Dam, to 370 Summit St., Elgin, Ill. 60120
Anderson, Paul D., 815 South 10th St., La Crosse 54601
Bassewitz, P. P., 520 Ontario Ave., Sheboygan 53081
Bates, Donald E., 311 South Main St., Fort Atkinson 53538
Bunke, John W., New London, Conn., to 614 E. College Ave., Waukesha 53186
Cejpek, Karel O., 815 South 10th St., La Crosse 54601
Cook, James C., Racine, to Star Route 1, Box 43, Iron Mountain, Mich. 49801
Da Costa, Wanir C., 815 South 10th St., La Crosse 54601
Durst, Joseph B., 815 South 10th St., La Crosse 54601
Esener, Ismail, Union Grove, to Floyd Hospital, Rome, Ga. 30161
Evrard, John R., Milwaukee, to 7109 North Santa Monica, Fox Point 53217
Fernando, Oscar U., Marshfield, to Staff Personnel, Naval Hospital, Portsmouth, Va. 23708
Gardner, L. C., 615 Grace Ave., Fond du Lac 54935
Gilbert, Robert L., 815 South 10th St., La Crosse 54601
Handeyside, Robert G., 311 South Main St., Fort Atkinson 53538
Harned, Roger K., Monroe, to 12624 Martha, Omaha, Neb. 68144
Herzberger, Eugene E., Madison, to 1515—10th St., Monroe 53566
Huewe, Douglas A., Milwaukee, to 609 Cherry St., Springfield, Mo. 65806
Kenwood, Stanley N., 8200 North Teutonia Ave., Milwaukee 53209
Luther, Thomas W., 215 South State St., Appleton 54911
O'Meara, Mark T., 815 South 10th St., La Crosse 54601
Ouellette, John J., 1912 Atwood Ave., Madison 53704
Roth, Harry, Madison, to 60 Amethyst Way, San Francisco, Calif. 94131
Satory, John J., 815 South 10th St., La Crosse 54601
Sholtes, C. A., Fort Atkinson, to 30 Gulf Breeze Drive, South, Port Richey, Fla. 33568
Stinson, H. Keith, Marshfield, to Yagaum Hospital, Madang, New Guinea
Tankersley, James C., 815 South 10th St., La Crosse 54601
Vermund, Halvor, Corona del Mar, Calif., to Orange County Medical Center, 101 South Manchester, Orange, Calif. 92668
Vognar, Stanley F., Fort Atkinson, to c/o M. Matesich, 164 Paseo de la concha, Apt. A, Redondo Beach, Calif. 90277

REMOVED FROM MEMBERSHIP

Connally, Joseph M., Jr., Dane County, transferred to Texas
Paetkau, Margaret E., Dane County, resigned
Stinchcomb, David E., Dane County, resigned
Weeks, James H., Green County, transferred to Pennsylvania

DEATHS

Trumbo, James K., Marathon County, June 20, 1969
Callan, Patrick L., Milwaukee County, Sept. 9, 1969 □

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PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physicion placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. (Widows of deceased member physicions are allowed to advertise without charge.) There is na additionol chorge for ods with Dept. numbers. For these ods address replies to: Dept. ___, %Wisconsin Medical Journol, Box 1109, Madison, Wis. 53701. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

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WANTED: General Practitioners, Ophthalmologists, Allergists, Internists, Dermatologists, Otolaryngologists, Urologists; excellent opportunities for solo or partnerships in Oshkosh, Wisconsin, population 50,000 with large state university; on Lake Winnebago in year-round resort area. Write William A. Crawford, MD, Mercy Medical Center, Oshkosh, Wis. 54901. p8-7, p8-1

MELLEN, WISCONSIN, seeking urgently needed general practitioner, Excellent professional opportunity to practice in friendly community. Growing industry and excellent educational facilities. In heart of recreational area. For complete details contact Raymond F. Ferrando, Mellen, Wis. 54546. p2–1

WANTED: BOARD ELIGIBLE or Certified Internist; Internal Medicine subspecialty, Urologist, Ophthalmologist; ENT; Orthopedist; and General Surgeon. Thirteen-man, all-specialty partnership group practice, two modern community hospitals. New brick, two-story clinic facility located in a growing community of 100,000 in southeastern Wisconsin. Contact: Stanley M. Englander, MD, Kurten Medical Group, Racine, Wis. 53404; tel. 414/637–9271. 6tfn

INTERNIST WANTED—BOARD CERTIFIED OR ELIGIBLE. Join two Internists, Radiologist, General Surgeon and EENT physician (all Certified). Modern clinic building located in University city of northeast Wisconsin having three fully equipped hospitals. Contact Dept. 325 in care of the Journal. p10–12

FOR SALE: X-Ray, 30 milliamp Universal (5 years old); EKG machine; % B. R. Bogost, MD, 9444 North Sleepy Hollow Lane, Milwaukee, Wis. 53217. 7tfn

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Presidents and secretaries of the 54 component county medical societies are listed periodically.

MEDICAL MEETINGS
POSTGRADUATE COURSES

1970 WISCONSIN

Jan. 22: "In-Depth" Teaching Program on "The Abused Child," State Medical Society of Wisconsin and University of Wisconsin Medical School, University Hospitals and SMS headquarters, Madison.

Feb. 10–12: Seventh Annual Telemark Symposium, Indianhead Chapter of Wisconsin Academy of General Practice, Mt. Telemark Ski Chalet, Cable.

Feb. 19: "In-Depth" Teaching Program on "Osteoporosis—Newer Diagnostic Methods and Evaluation of Therapy," State Medical Society of Wisconsin and University of Wisconsin Medical School, University Hospitals and SMS headquarters, Madison.

Mar. 11: Conference on the Provision of Occupational Health Services to the Small Industrial Plant, Racine Motor Lodge, Racine (sponsored by the Committee on Occupational Health of the State Medical Society of Wisconsin).

Mar. 12–14: Infectious Disease Conference, University of Wisconsin, Department of Postgraduate Medicine and Department of Pediatrics, Wisconsin Center, Madison.

Mar. 18: "In-Depth" Teaching Program on "Psychotherapeutic Drugs," State Medical Society of Wisconsin and University of Wisconsin Medical School, University Hospitals and SMS headquarters, Madison.

Mar. 18: Symposium on Farm Accidents, Valhalla Hall, Wisconsin State University at La Crosse (sponsored by Committee on Occupational Health of the State Medical Society of Wisconsin).

Apr. 1–2: Fifth Postgraduate Teaching Days in Sports Medicine, University Extension, Department of Postgraduate Medical Education, University of Wisconsin, Wisconsin Center, Madison.

Apr. 9–10: National Conference on Rural Health, American Medical Association, Pfister Hotel and Tower, Milwaukee.

Apr. 11: Second Annual Southeastern Wisconsin Cancer Conference—Carcinoma of the Colon and Rectum, Ramada Sands Inn, Milwaukee.

Apr. 16: Perinatal Care Conference, University Extension, Department of Postgraduate Medical Education, University of Wisconsin, Wisconsin Center, Madison.

Apr. 24–25: Wisconsin Urological Society meeting, Wisconsin Center, Madison.

Apr. 25–26: Ophthalmic–Pathology Society meeting, Wisconsin Center, Madison.

May 4–6: One-hundredth Anniversary Meeting, Wisconsin State Dental Society, Milwaukee

May 11–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June: 15th Annual State Convention, Wisconsin State Medical Assistants Society, Janesville.

1970 NEIGHBORING STATES

Jan. 14: Frontiers of Medicine (fifth series)—Recent Progress in Human Genetics, University of Chicago, Chicago.

Feb. 11: Frontiers of Medicine (fifth series)—Abnormal Uterine Bleeding and Pain, University of Chicago, Chicago.

Feb. 16–18: Sectional meeting, American College of Surgeons, St. Paul Hilton, St. Paul, Minn.

Mar. 1–4: Midwest Clinical Conference of the Chicago Medical Society, The Sherman House, Chicago.

Mar. 11: Frontiers of Medicine (fifth series)—Gout and Purine Metabolism, University of Chicago, Chicago.

Mar. 16–20: Clinical Problems in Internal Medicine, American College of Physicians, Cleveland, Ohio.

Mar. 23–26: Neurology and the Internist, American College of Physicians, Rochester, Minn.

Mar. 30–Apr. 3: Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, American College of Physicians, Ann Arbor, Mich.

Apr. 8: Frontiers of Medicine (fifth series)—Therapy of Leukemia and Lymphoma, University of Chicago, Chicago.

Apr. 13–16: American Industrial Health Conference, Palmer House, Chicago, Ill.

May 13: Frontiers of Medicine (fifth series)—Neurological Aspects of Systemic Disease, University of Chicago, Chicago.

June 8–12: Internal Medicine, 1970—Old Principles, New Practice, American College of Physicians, Iowa City, Iowa.

June 15–17: Blood Transfusion Therapy and Related Immunology, American College of Physicians, East Lansing, Mich.

Oct. 5–9: 53rd Annual Meeting, American Dietetic Association, Detroit, Mich.

Oct. 12–16: Annual Clinical Congress, American College of Surgeons, Chicago.

Nov. 2–6: Annual session, American Association for Laboratory Animal Science, Conrad Hilton Hotel, Chicago.

1970 OTHERS

Jan. 2–6: PG course on "Function and Dysfunction of the Gastrointestinal Tract," University of Miami School of Medicine, at The Americana Hotel, Bal Harbour, Fla.

Jan. 4–17: Pacific Cancer Conference, American Cancer Society, Hawaii Division, Honolulu, Hawaii.

Jan. 8–11: Seventh Annual Postgraduate Seminar on "Advances in Respiratory Care and Physiology," University of Miami School of Medicine, at Eden Roc Hotel, Miami Beach, Fla.

Jan. 9: Sectional Meeting, American College of Surgeons, Americana Hotel, San Juan, Puerto Rico.

Jan. 14–15: PG course on "Selected Problems in General Surgery and Vascular Surgery," Cleveland Clinic Educational Foundation, Ohio.

Jan. 16–17: Sectional Meeting, American College of Surgeons, Mancuto–Sheraton Hotel, Caracas, Venezuela.

Jan. 18–24: Sixteenth Annual General Practice Review, University of Colorado School of Medicine, Denver.

Jan. 21–23: Sectional Meeting, American College of Surgeons, El Panama Hotel, Panama City, Panama.

Jan. 23–25: Eighth Clinical Conference in Pediatric Anesthesiology, Childrens Hospital of Los Angeles, Calif.

Feb. 1–4: Theodor Billroth Course in Surgical Anatomy, Loma Linda University School of Medicine, Loma Linda, Calif.

Feb. 2–4: Sectional Meeting, American College of Surgeons, Portland Hotel, Portland, Ore.

Feb. 2–6: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Feb. 12–14: Second National Conference and Exposition on Electronics in Medicine, Electronics/Management Center of McGraw–Hill Publications Company, Fairmont Hotel, San Francisco, Calif.

Feb. 14–15: PG Course on Allergy, Immunology, and Related Fields at 26th Annual Meeting of American Academy of Allergy, Jung Hotel, New Orleans, La.

Feb. 14–21: Fourth Annual Alumni/Faculty Retreat, Wisconsin Medical Alumni Association, Puerto Vallarte, Mexico.

Feb. 17–20: PG Course on Surgery of the Hand, University of Colorado School of Medicine, Humphreys Postgraduate Center, Denver, Colo.

Feb. 18–20: Frontiers of Medicine 1970, Lakeland Graduate Medical Assembly, Lakeland, Fla.

Feb. 25–Mar. 1: Nineteenth Annual Scientific Session, American College of Cardiology, Rivergate Center, New Orleans, La.

Mar. 2–5: Annual meeting, The New Orleans Graduate Medical Assembly, The Roosevelt Hotel, New Orleans, La.

Mar. 9–27: Course for physicians in Occupational and Environmental Medicine, New York University Post-Graduate Medical School, New York.

Mar. 16–18: Sectional Meeting, American College of Surgeons, Sheraton Park Hotel, Washington, D.C. (Combined annual meeting for surgeons and nurses).

Apr. 6–10: Course on High Risk Infant Care, University of Colorado School of Medicine, Denver.

Apr. 10–18: Medical Tour to the Soviet Union, Perry Elfmont, MD, Director, 235 East 57th Street, New York, N.Y. 10022; tel. HA 1–3229.

Apr. 11–12: Fifteenth Annual PG Assembly, The Los Angeles County Society of Anesthesiologists, Los Angeles Hilton Hotel, Calif.

Apr. 15–17: Course on "The Management and Care of Respiratory Insufficiency," U of Colo School of Medicine, Denver.

Apr. 26–30: First International Congress on Group Medicine, Winnipeg, Manitoba, Canada.

May 4–5: 1970 Annual Cancer Seminar, American Cancer Society—Nevada Division, Frontier Hotel, Las Vegas, Nev.

May 7–9: Annual Meeting, American College of Sports Medicine, Albuquerque, N.M. (Exec. Secy.: Mr. Donald E. Herrmann, 1440 Monroe St., Madison, Wis. 53706).

May 13–22: Annual Congress and Teaching Seminar of the International Academy of Proctology, Spain.

May 22–29: Tenth International Cancer Congress, Houston, Tex.

July 6–9: Course on Ophthalmology, U of Colo School of Medicine, Estes Park.

July 19–22: Course on Pediatrics, U of Colo School of Medicine, Aspen.

July 27–31: Course on Internal Medicine, U of Colo School of Medicine, Estes Park.

Aug. 3–7: Sixteenth Annual General Practice Review, U of Colo School of Medicine, Denver.

Aug. 9–14: First International Symposium on Plastic and Reconstructive Surgery of the Face and Neck, Waldorf–Astoria, New York City.

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 20–25: Annual meeting, Michigan State Medical Society, Detroit.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

Oct. 5–9: Course on High Risk Infant Care, U of Colo School of Medicine, Denver.

Dec. 6–11: Second International Clean Air Congress, Washington, D. C.

1970 AMA

Apr. 9–10: Rural Health Conference, American Medical Association, Pfister Hotel and Tower, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1971 NEIGHBORING STATES

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

For listing of other meetings see the **Journal of the American Medical Association.**

WAGP Telemark Symposium—Cable

The 7th Annual Telemark Symposium and ski outing will be held at the Mt. Telemark ski chalet on Tuesday, Wednesday, and Thursday, Feb. 10–12.

The meeting is sponsored by the Indianhead chapter of the Wisconsin Academy of General Practice. It is open to all physicians. Mt. Telemark, a popular ski area in the state, is located near Cable, Wisconsin, in the northwestern part of the state.

A faculty from the Mayo Clinic will again present a three-day scientific program of general interest. The program is acceptable for six hours of prescribed credit by the AAGP.

The program will begin at 3 PM each day, which allows ample time for skiing. On Tuesday evening after the scientific program there will be a get-together party for all participants and their wives. On Wednesday afternoon at 3:30 PM there will be a fashion show for wives, featuring the latest in ski and apre ski attire.

There are many motels in the area. For room reservations and further information as to accommodations, write to: Manager, Mt. Telemark Ski Area, Cable, Wis.

The complete program follows:

TUESDAY, FEB. 10 (3:00 PM)—*Spinal Anesthesia,* Paul Leonard, MD; *Rheumatic Fever,* William Weidman, MD; *Practical Considerations of Urological Diagnosis,* William Furlow, MD; and *Breech Presentation,* Carl Johnson, MD.

WEDNESDAY, FEB. 11 (3:00 PM)—*Newborn Resuscitation,* Dr. Leonard; *Treatment of the Child with Congenital Heart Disease,* Dr. Weidman; *Prostatitis and Prostatism: Every Man's Disease?,* Dr. Furlow; and *Transverse Presentation,* Dr. Johnson.

THURSDAY, FEB. 12 (9:00 AM)—*Contraception,* Dr. Johnson; *Electrical Hazards in the Hospital,* Dr. Leonard; *Idiopathic Hypertrophic Subaorta Stenosis—Recognition and Treatment,* Dr. Weidman; and *Management of the Prostatic Nodule,* Dr. Furlow.

Surgeons' Sectional Meeting—St. Paul

The American College of Surgeons will hold the second of three 1970 Sectional Meetings in St. Paul, Minn., Feb. 16–18. Some 550 surgeons are expected to attend this intensive three-day program, open to all doctors of medicine. This is the first ACS meeting in St. Paul since 1957. Headquarters is the St. Paul Hilton.

Dr. Frederick M. Owens, Jr., clinical associate professor of surgery, University of Minnesota Medical School, and his local advisory committee on arrangements, have selected a distinguished faculty to present "How-I-Do-It" clinics, panel discussions, scientific papers, symposia, and medical films in general surgery and the specialties of otorhinolaryngology, thoracic surgery, and urology.

Subjects to be covered include vascular surgery, rhinoplasty and septoplasty, mediastinoscopy, perforation of the esophagus, cardiac injuries, emergency treatment of head injuries in Viet Nam, arterial surgery for renal disease, prostatic carcinoma, Wilm's tumor, carcinoma of the breast, and transportation of the injured patient.

Four Wisconsin physicians will be participating in the program: Dr. Edwin H. Ellison, Milwaukee; Dr. Anthony Curreri, Madison; Dr. Joseph D. Farrington, Minocqua; and Dr. William H. Frackelton, Milwaukee.

Doctor Farrington also will be showing a film entitled "Before the Emergency."

Hotel reservation forms may be obtained by writing directly to the St. Paul Hilton, St. Paul, Minn. 55101, or Mr. T. E. McGinnis, ACS, 55 East Erie Street, Chicago, Ill. 60611.

No registration fee is charged fellows of the College, members of the candidate group, residents or interns who present letters of identification signed by chiefs of surgery or the hospital administrator. Non-fellows pay $15.00. Doctors in the federal services pay $7.50.

The 56th Annual Clinical Congress of the ACS has been scheduled for Oct. 12–16 at Chicago.

Frontiers of Medicine 1970—Florida

Registrations are being accepted for Frontiers of Medicine 1970 to be held in Lakeland, Fla., Feb. 18–20. The meeting, sponsored by the Lakeland Graduate Medical Assembly, has been approved by the American Academy of General Practice for 14 hours elective credit.

A wide range of current medical topics is offered by this year's Frontiers of Medicine program with an outstanding guest faculty from throughout the United States.

Co-sponsors of the Frontiers meeting—which last year was highlighted by Drs. Christiaan Barnard and Denton Cooley—are the medical staffs of Winter Haven Hospital and Bartow Memorial Hospital.

Registration fee is $100. For details, contact the Lakeland Graduate Medical Assembly, P.O. Box 2335, Lakeland, Fla. 33830 (813/683–1636 or 683–2038).

Surgery Course—Cleveland Clinic

The Cleveland Clinic Educational Foundation will offer a postgraduate course in Surgery on Jan. 14 and 15, entitled "Selected Problems in General Surgery and Vascular Surgery."

Staff members of the Cleveland Clinic Foundation assisted by several guest speakers will present the course which has a registration fee of $50.00.

Guest speakers are: John J. Bergan, MD, associate professor of surgery, Northwestern University, Chicago; Emil Frei, III, MD, associate director (chemotherapy), M.D. Anderson Hospital and Tumor Institute, Houston, Tex.; John L. Madden, MD, director of surgery, St. Clare's Hospital, New York, N. Y.; and Edwin J. Wylie, MD, professor of surgery, University of California, San Francisco Medical Center, San Francisco.

Registrations will be accepted in the order of application. Contact: Education Secretary, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

New Orleans Graduate Medical Assembly

The 33rd annual meeting of the New Orleans Graduate Medical Assembly will be held March 2–5 with headquarters at The Roosevelt Hotel, New Orleans, La.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 50 informative discussions on many topics of current medical interest, in addition to a clinicopathologic conference, symposia, medical motion pictures, roundtable luncheons, and technical exhibits.

This program is acceptable for 22 prescribed hours and 9 elective hours by the American Academy of General Practice.

An interesting and enjoyable program of entertainment for visiting ladies has been planned.

Of special interest will be a one-day, pre-assembly symposium scheduled for Sunday, March 1, on "The Price of Medical Progress," presented by noted authorities. This symposium is acceptable for 6 prescribed hours by the AAGP. This session will be strictly limited to physicians and their wives.

For more details of the program see the advertisement in this issue at page 53.

For further information, contact Secretary, Room 1538, 1430 Tulane Avenue, New Orleans, La. 70112.

"Infectious Diseases" Conference—Madison

The University of Wisconsin, Department of Postgraduate Medicine and Department of Pediatrics, will sponsor a two and one-half day conference March 12–14 on "Infectious Diseases."

The spectrum of infectious disease problems in pediatrics continues to shift as new antibiotics and vaccines emerge and as further developments in concepts of pathogenesis alter clinical evaluation and approach. The goal of this course is to achieve a general understanding of these advances and their applications to problems of pediatric practice.

Guest speakers will include: Dr. Donald N. Medearis, Jr., dean, University of Pittsburgh Medical School; Dr. David H. Carver, associate professor of pediatrics, Johns Hopkins Medical School; Dr. Martha Yow; professor of pediatrics, Baylor University School of Medicine; Dr. David Smith, associate professor of pediatrics, Harvard Medical School; and Dr. Eli Gold, professor of pediatrics, Case Western Reserve University.

For further information write to: Thomas C. Meyer, MD, Chairman, Department of Postgraduate Medicine, 307 N. Charter Street, Madison, Wis. 53706.

Doctors–Nurses Joint Meeting—Washington, D. C.

The annual combined meeting for doctors and nurses sponsored by the American College of Surgeons will be held in Washington, D.C. March 16–18. The meeting, at the Sheraton Park Hotel, is open to all doctors of medicine and registered nurses.

The doctors' program will include sessions in general surgery and the specialties of gynecology–obstetrics, neuro-

Spring 1970

Occupational Health Conferences

Racine and La Crosse

The State Medical Society of Wisconsin, through its Committee on Occupational Health of the Commission on Health Information, will sponsor two scientific programs in the spring of 1970.

On Mar. 11 a Conference on the Provision of Occupational Health Services to the Small Industrial Plant will be held at the Racine Motor Lodge in Racine. Dr. Louis Olsman of Kenosha, a member of the Committee, will have charge of this program.

On Mar. 18 a Symposium on Farm Accidents will be held at Valhalla Hall on the Wisconsin State University at La Crosse campus in La Crosse. Dr. Allen G. Brailey, Jr. of La Crosse, also a member of the Committee, will conduct this program.

surgery, ophthalmic surgery, orthopedic surgery, otolaryngology, plastic surgery, and urology. Topics include renal complications of surgery, advances in chemotherapy, current status of surgery in sinus disease, 1970 management of neurogenic bladder, management of combat facial wounds, infertility in the female, glaucoma—when and how to operate, cup arthroplasty of the hip and long-term results of lumbar disc surgery.

Nurses' sessions will focus on management of thoracic surgery patients, status of OR technicians and medical assistants, chromosomes and malignancies, the surgeon looks at the operating room environment, and papers on arthritis and electricity.

Hotel reservation forms may be obtained by writing directly to the Sheraton Park Hotel, Washington, D.C. 20008; or Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611.

International Symposium on Plastic Surgery

The First International Symposium on Plastic and Reconstructive Surgery of the Face and Neck will be held Aug. 9–14 at the Waldorf–Astoria in New York City.

This symposium provides an opportunity to join 200 of the world's outstanding facial plastic and reconstructive surgeons for in-depth discussions.

Ranging the spectrum from rhinoplasty to rhytidectomy, blepharoplasty and otoplasty, the symposium is designed to provide as broad as possible in-depth studies of facial paralysis, cleft palate, premaxillary defects, burns, skin grafts, hemangiomas, cancer, trauma, and x-ray dermatitis research.

An internationally-distinguished faculty has been invited to help stimulate individual professional growth in the surgery specialties of otolaryngology, general plastic surgery, general surgery, ophthalmology, maxillo-facial surgery, and oral surgery.

Program chairman is John Conley, MD, 139 East 36th Street, New York, N.Y. 10016.

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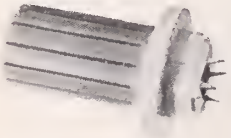

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Conference on Rural Health—Milwaukee

The 23rd National Conference on Rural Health will be held Apr. 9–10 at the Pfister Hotel and Tower in Milwaukee.

Sponsored by the American Medical Association, the conference has as its theme "Let's Put YOU in Comm-U-nity Health." There will be a number of Wisconsin physicians participating in the program which will be announced later.

Medical Tour to the Soviet Union

Dr. Perry Elfmont of New York City, as director of the tour, has announced that an eight-day medical tour to the Soviet Union is being arranged for April 10–18 with visits to Moscow and Leningrad and including a comprehensive medical program.

The all-inclusive rate is $495 from New York. Travel arrangements are being handled by Compass Travel Bureau, Inc., 55 West 42nd Street, New York, N.Y. 10036, to which all inquiries should be directed. Flights are on Pan American World Airways scheduled direct service to Moscow.

SE Wisconsin Cancer Conference

The Second Annual Southeastern Wisconsin Cancer Conference will be held on April 11 at the Ramada Sands Inn in Milwaukee. Topic for the conference is "Carcinoma of the Colon and Rectum."

Further information may be obtained by writing Joseph J. Gramling, Jr., MD, Chairman, St. Joseph's Hospital, 5000 West Chambers Street, Milwaukee, Wis. 53210.

International Academy of Proctology—Spain

The 22nd Annual Congress and Teaching Seminar of the International Academy of Proctology will be held May 13–22 in Spain. Wet clinics are scheduled in Barcelona on May 15 and 16 at the Clinique Quiron on closed circuit television, under the direction of Dr. Javier Lentini.

Academy business sessions will take place May 18 in Palma, Mallorca, and the scientific sessions will take place each morning, Monday through Friday, May 17–22, at the Palace for Congresses in Palma.

The sessions are open to all physicians who desire to attend, but particularly the proctologists and gastroenterologists.

Dec. 31 is the deadline for all registrations. Full information may be obtained by contacting the Executive Office, 147–41 Sanford Avenue, Flushing, N.Y. 11355.

SMS Annual Meeting May 12–14, 1970

The State Medical Society of Wisconsin's Commission on Scientific Medicine has been diligently planning the 1970 Annual Meeting scheduled for May 12–14 in Milwaukee. Much of the program has been formalized with particular emphasis to socio-economic subjects as well as the scientific aspects.

Featured on Tuesday, May 12, will be Internal Medicine, Radiology, and Pathology. Dr. James W. Manier of the Marshfield Clinic has arranged an all-day program for those physicians interested in Internal Medicine. Featured speaker for this program will be Dr. James E. McGuigan of the University of Florida College of Medicine, Gainesville. His topic is "Immunologic Assay of Gastrin—Relationship to Gastric and Duodenal Ulcer."

Dr. Alfred Meyers of Marquette School of Medicine is in charge of the Pathology program which will feature

noted Wisconsin pathologists and a microbiologist, Silas Farmer, PhD, of Milwaukee County General Hospital.

Featured on the Radiology program is Dr. Atis K. Freimanis of Ohio State University Hospitals, Columbus.

The Wednesday, May 13, program includes the specialties of Obstetrics-Gynecology, Allergy, Dermatology, and Neurology-Pediatrics. Dr. Samuel G. Perlson of Milwaukee, president of the Wisconsin Society of Obstetrics and Gynecology, is arranging the all-day program on OB-GYN.

Two out-of-state speakers have accepted assignments: Dr. Russell K. Laros of the University of Michigan Medical School, Ann Arbor; and Dr. Duncan E. Reid of Harvard Medical School, Boston, Mass.

Dr. Samuel C. Bukantz of New York University will be a featured speaker at the Allergy session which is being arranged by Dr. A. J. Sosman of Milwaukee.

The dermatologists will present again this year brief talks on current problems with a question and answer period. Dr. Frank H. Urban of Wauwatosa, president of the Wisconsin Dermatological Society has been invited to chairman this program.

The neurologists and pediatricians will have a combined

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1969-1970

"In-Depth" Teaching Programs

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POSTGRADUATE PROGRAM—MERCK SHARP AND DOHME

SCHEDULE: 10:00 a.m.—University Hospitals for patient discussions, Room 300, Third Floor (except for Dec. 3 program which will be held at Gymnasium Unit II of the University Natatorium); 12:30 p.m.—Lunch at State Medical Society headquarters (included in fee); 1:15–4:00 p.m.—Program at SMS. CREDIT: Five hours AAGP credit. FEE: $5.00 per meeting, $20.00 for all four. ADVANCE REGISTRATION: David C. Reynolds, State Medical Society, Box 1109, Madison, Wis. 53701.

THURS. JAN. 22 1970

THE ABUSED CHILD

Faculty:
CHARLES C. LOBECK, M.D.; JACK C. WESTMAN, M.D.; RICHARD WESENBERG, M.D.; MARYGOLD S. MELLI, LL.B.; MR. MAX WALD

Topics:
"Presentation of Patients" . . . "Extent of the Problem in Wisconsin and the Nation" . . . "The Law and the Abused Child" . . . "Clinical Diagnosis of Child Abuse" . . . "Why Is a Child Abused"

THURS. FEB. 19 1970

OSTEOPOROSIS—NEWER DIAGNOSTIC METHODS AND EVALUATION OF THERAPY

Faculty:
MARK N. MUELLER, M.D.; JOHN R. CAMERON, Ph.D.; JOHN JURIST, Ph.D.; RICHARD MAZESS, Ph.D.; MR. GARY FULLERTON

Topics:
"Dimensions of the Problem of Osteoporosis in the U.S." . . . "Physical Methods in Assessing Bone Mineral Content" . . . "Resonant Frequency of Bone as a Measure of the Quality of the Organic Component of Bone" . . . "Skin Thickness and Transparency: Correlation with Presence of Osteoporosis and Its Severity" . . . "Osteoporosis in Rheumatoid Arthritis—Relationship to Duration and Severity of Disease and Therapy of Arthritis" . . . "Evaluation of Therapy of Osteoporosis"

WED. MAR. 18 1970

PSYCHOTHERAPEUTIC DRUGS

Faculty:
BEN H. GLOVER, JR., M.D.; JOSEPH M. BENFORADO, M.D.; CARL H. FELLNER, M.D.; JOSEPH GREEN, M.D.; JOSEPH G. KEPECS, M.D.; ARNOLD LUDWIG, M.D.; WILLIAM McKINNEY, M.D.; GILBERT TYBRING, M.D.

Topics:
"Clinical Use of New Psychotherapeutic Drugs" . . . "Therapeutic Drug Effects (Clinical Presentation)" . . . "Treatment without Drugs" . . . "Experience with Experimental Drugs" . . . "Alcoholism and Drug Therapy" . . . "Children and Psychotherapeutic Drugs" . . . "Basic Pharmacology and Toxicology of Psychotherapeutic Drugs"

program chairmened by Dr. Frank C. Stiles of Monroe, chairman of the Wisconsin Chapter of the American Academy of Pediatrics; and Dr. Raymond W. M. Chun, Madison, associate professor of pediatrics and neurology, University of Wisconsin Medical School. Dr. Sidney Carter of the College of Physicians and Surgeons, Columbia University, New York, will be a featured speaker.

The resident-intern papers will be presented on Thursday, May 14 under the chairmanship of Dr. Jack A. Killins of Green Bay, chairman of the Commission on Scientific Medicine.

Also on May 14 there will be all-day programs on Otolaryngology, General Practice, and Surgery. Anesthesia, Ophthalmology, and Orthopedics will be covered in the afternoon only.

Dr. Frank N. Ritter of the University of Michigan Medical Center will be featured on the Otolaryngology program whose chairman is Dr. Howard V. Morter of Marquette School of Medicine, Milwaukee.

Dr. J. N. Pallin of Fond du Lac will chairman the Anesthesia program. Doctor Pallin is president of the Wisconsin Society of Anesthesiologists.

Dr. Philip D. Wilson, Jr. of New York will be featured on the Orthopedics program whose chairman is Dr. Fred G. Gaenslen of Milwaukee.

The Family Practice Day, also on Thursday, May 14, will have as its co-chairmen Dr. G. J. Derus of Madison and Dr. J. N. Moore of Madison, education committee chairman of the Wisconsin Academy of General Practice. Dr. Francis L. Lederer of Chicago, president of the American Otological Society, Inc. and emeritus professor and head of the Department of Otolaryngology of University of Illinois Eye and Ear Infirmary, will speak in the morning and again at a roundtable luncheon. In the afternoon Dr. Paul F. Maddox of Campton, Ky., and Dr. Thomas D. Darby, PhD of Louisville, Ky., professor and chairman of the Department of Pharmacology, University of Louisville School of Medicine, will make presentations.

A special program on "Modern Therapeutic Pharmacology" is being arranged by Dr. Richard I. H. Wang, chief of pharmacology at the Veterans Administration Center, Wood. There will be eight guest lecturers discussing the eight most commonly used drugs in this country.

The surgery program will start out Thursday morning with the usual "wet clinic" followed in the afternoon by a scientific program being arranged by the Section on Surgery of the State Medical Society.

Annual Laboratory Animal Science Session

The 21st Annual Session of the American Association for Laboratory Animal Science will be held Nov. 2–6 at the Conrad Hilton Hotel, Chicago. Further details will be available early next year.

Western Cancer Seminar—Las Vegas

On May 4–5 the American Cancer Society, Nevada Division, will sponsor the 12th Annual Cancer Seminar in Las Vegas, Nev., at the Frontier Hotel. Ten leading physicians from throughout the United States have accepted to speak to this assembly.

The seminar will emphasize roundtable discussions of faculty with participants. Topics to be included are: Leukemias and Lymphomas; Head and Neck Chemotherapy; Use of Chemotherapeutic Agents; Mammography and Thermography; Terminal Patient Management, and others.

There also will be a nurses' program and activities for wives. The AAGP will allow 12 hours credit. Registration is limited to doctors of medicine and dentistry, licensed nurses, and medical and nursing students.

Further details may be obtained by writing: Nevada Division, Inc., American Cancer Society, 301 S. Highland Drive, Las Vegas, Nev. 89106.

Congress on Group Medicine—Canada

Early registration is recommended for the First International Congress on Group Medicine to be held at The Manitoba Centennial Concert Hall in Winnipeg, Manitoba, Canada, Apr. 26–30.

Congress sessions will take up the following subjects: Socioeconomic Philosophy of Health Care, Group Medicine and Health Care, Group Practice in Many Lands, Health Care Delivery and Cost Control, Research and Education in Group Medicine, University-Based and Community-Based Group Medicine, Role of the Allied Health Professions in Group Medicine, Management Problems in Group Medicine, and The Role of Government as a Catalyst in the Planning and Delivery of Comprehensive Health Services.

Post-Congress tours have also been planned.

Registration to: Paul H. T. Thorlakson, MD, President and General Chairman, 425 St. Mary Avenue, Winnipeg 1, Manitoba, Canada. □

STUDY OF ADAPTIVE CHANGES IN OXYGEN TRANSPORT PUBLISHED IN MONOGRAPH SERIES

As Number 23 in its Monograph Series, the American Heart Association has issued an 80-page publication based on a longitudinal study of adaptive changes in oxygen transport and body composition. Entitled "Response to Exercise After Bed Rest and After Training," the investigation was conducted by Drs. Bengt Saltin, Gunnar Blomqvist, Jere H. Mitchell, Robert L. Johnson, Jr., Kern Wildenthal and Carleton B. Chapman.

The publication is intended to provide more light on the complex manner in which man adapts to muscular exercise. The study investigated the capacity of an individual to adapt to long periods of exercise, rather than measure a group of individuals at various stages over short periods of time. Both the capacity to return to normal activity after prolonged bed rest and, in the case of athletes, to resume training, are covered.

Of interest to cardiologists, internists, general practitioners, physiologists, psychiatrists, physical therapists and education specialists, the new publication may be obtained through local Heart Associations or the AHA National Office, 44 E. 23rd St., New York, N.Y. 10010.

Wisconsin Heart Association: 205 West Highland Ave., Milwaukee, Wis. 53203; tel. 414/272–4246. □

MEDICAL TEACHING FILMS AVAILABLE

The Eaton Laboratories library of surgical and medical science teaching films has added eight new titles—with still others in production—since the revised film catalog was published last spring.

All 16mm, sound, color films, they are:

The Embryology of the Male External Genitalia, by Charles J. Devine, Jr, MD; *Surgical Anatomy of the Flank: Twelfth Rib Approach to the Kidney,* by Winston K. Mebust, MD; *Surgical Anatomy of the Female Reproductive System. Part I: The Anterior Abdominal Wall,* by Kermit E. Krantz, MD; and *Surgical Treatment of Renal Trauma. Part I: The Kidney,* by Russell Scott, Jr, MD, and C. E. Carlton, MD.

Also, *Distal Urethral Stenosis, Difficult Urination and Infection,* by Richards P. Lyon, MD; *Urethral Suspension Using Stainless Steel Staples,* by C. Allen McKnight, M.D; *Surgical Correction of Hydronephrosis: Non-Dismembering Procedures,* by W. R. Smart, MD; and *Surgical Correction of Hydronephrosis: Dismembering Procedures,* also by Doctor Smart. All these films run approximately 20 minutes.

For further information or to schedule showings, contact any Eaton medical sales representative or write Eaton Medical Film Library, Eaton Laboratories, Division of The Norwich Pharmacal Company, Norwich, N. Y. 13815. □

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

IMPORTANT NOTICE TO THE SOCIETY MEMBERSHIP!

We, the members of the Wisconsin Delegation to the House of Delegates of the American Medical Association, have just returned from several days in Denver meeting with the other state medical society delegations.

We considered the report of the Committee on Planning and Development to be the single most important piece of "legislation" to come before the AMA House in many years. During the meeting, we urged that the membership of our societies have an opportunity to review and evaluate the entire report before final action is taken. Our view prevailed.

As a result, the full report, including the minority report, is being prepared by the AMA for distribution to state and county medical societies. You and your society are urged to study the report and make any recommendations and resolutions you deem appropriate. These are to be in the hands of the AMA in time for consideration of the House of Delegates when it meets in Chicago in June 1970.

We have asked our State Society staff to prepare the accompanying summary of the planning and development report. We point out that it is a "summary" and that you should seek to review the full report as soon as it is available.

If you would like a copy of the full report, with the minority report, please write to the State Medical Society office in Madison.

This delegation believes you should give the matter thorough discussion and thought at the county societies and express your opinions. We will appreciate hearing from you.

Delegates

J. M. Bell, MD, Marinette
E. L. Bernhart, MD, Milwaukee
C. J. Picard, MD, Superior
R. E. Galasinski, MD, Milwaukee
W. B. Hildebrand, MD, Menasha

Alternate Delegates

J. C. Fox, MD, La Crosse
H. J. Kief, MD, Fond du Lac
D. J. Carlson, MD, Milwaukee
G. E. Collentine, MD, Milwaukee
N. A. Hill, MD, Madison

Urge Members to Give Views on Proposed Revamp of AMA Policies and Program

POTENTIALLY, the most significant development of the recent history of American Medical Association has been handed over to the State and County Medical Societies of the nation for reaction.

At the Clinical Meeting of the AMA in Denver, November 30 to December 3, the House of Delegates received a report of the Committee on Planning and Development which outlined proposals not only for the revamping of the organizational structure of the AMA but also made recommendations concerning the long-range objectives, resources, and programs of the Association.

The Wisconsin delegation to the AMA meeting joined with the majority of delegates in sensing the sweeping changes involved in philosophy and program and were active in the effort to refer the entire proposal to State and County Societies for review, comment, and reaction.

A report of the committee was 60 pages in length and one of the members of the committee submitted a minority report of six pages.

This issue of the Green Sheet will attempt only to outline the report and present the specific recommendations mentioned in it. Interested physicians are urged to write to the State Society to obtain a copy of the full report which will be made available by the AMA in the near future.

The following is a brief summary of some of the explanatory material in the report. Recommendations, wherever made, are printed in full.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1969 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

Premise No. 1:

The principle that the needs of the public for health services must be fully met are not clearly stated in the "Purposes and Responsibilities" of the AMA.

Recommendations:

(1) That the AMA adopt the following as a statement of the primary purpose and responsibility of the Association and the medical profession:

> "To endeavor, by all appropriate means, to make health services of high quality available to all individuals, in a dignified and acceptable manner, regardless of their social class, ethnic origin, ability to pay for services, or the source of the payment."

(2) The adoption of the following as a corollary or, rewritten, as a separate policy statement:

> "The American Medical Association has the duty to guide and assist the medical profession in the attainment of this objective."

Premise No. 2:

The Association should encourage and actively participate in devising practice patterns and delivery systems that are efficient, economical and non-restrictive for both the provider and the consumer.

Recommendations:

That, while the AMA must be prepared to accept some circumscription of the traditional privileges and freedoms of physicians, the following policy be adopted:

> "That the American Medical Association recognize the need for new and improved methods of delivering health services, that it encourage and participate in efforts to develop them, and
>
> "That, in the interest of attracting the most highly qualified candidates to the field of medicine, it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are minimal regimentation, a multiplicity of practice options, and freedom of choice for both physicians and patients."

Premise No. 3:

The AMA must adopt a definition of the term "health" to establish the dimensions of the health care field in which it will function.

Recommendation:

That the AMA officially adopt the following World Health Organization definition of health:

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Premise No. 4:

The AMA must decide on how large a role it should claim in planning for the future in health care.

Recommendation:

That AMA adopt an active role and take the initiative in developing *all* plans and programs for health care in *all* their ramifications and that it encourage and assist state and county medical societies to do the same at their respective levels.

Premise No. 5:

The report then evaluated current trends in medical practice, the effects of recent legislation such as Medicare, Medicaid, Regional Medical Programs, Comprehensive Health Planning, the demand for health services, and the shortage of medical and paramedical personnel.

Recommendations:

(1) That an appropriate committee or division of the Association secure data from all the state medical societies on the adequacy of health services and the manner in which they are being provided in their rural and underprivileged areas, and the practice mechanisms, if any, that are being considered or

developed to correct existing deficiencies. Based on this information, the same committee should devise delivery systems consonant with the Association's principles and incentives for physicians to settle in medically deprived localities.

(2) That the Association, in conjunction with state and county medical societies, establish a service of consultation and assistance for such physicians to facilitate the planning and financing of their projects.

(3) That, in those instances in which physicians cannot be found to develop health care facilities with the capability of providing needed services, the AMA urge, encourage, and assist the state and local medical societies to do so on an operational basis.

(4) That the Association study the possibility of establishing a corporation for this purpose, with subsidiary corporations at state and local levels. All such corporations should be legally empowered to receive payments for services rendered and would apply surplus income over expenditures to activities designed to improve health care in their areas, both quantitatively and qualitatively.

(5) That the AMA and the constituent and component medical societies seek the active involvement of medical centers and voluntary hospitals in health service projects for the medically underprivileged.

Premise No. 6:

The supply of family physicians represents another major deficiency, but to find a solution to this matter alone is an over-simplification of the problem.

Recommendations:

(1) That the AMA, through its Council on Health Manpower, in conjunction with other professional, educational, and lay associations, continue to explore and develop expedients to overcome health manpower shortages.

(2) That the Association, in its future declarations and activities directed toward the alleviation of shortages in health services and personnel, underscore the fact that these shortages are *not* due merely to an insufficient number of health professionals across-the-board, and emphasize that maldistribution of practitioners geographically, by profession, and by specialty is an equally important factor in depriving communities of an adequate supply and spectrum of health services.

(3) That the Association publicize the reasons for the maldistribution, as outlined in this section, and stress that the *voluntary* correction of these deficiencies requires public cooperation and community action in addition to the measures taken by the health professions.

Premise No. 7:

One method of increasing the productivity of physicians is the use of "Doctors' Assistants."

Recommendations:

(1) That an appropriate Committee of the AMA immediately begin to formulate a policy on doctors' assistants, particularly with regard to their responsibilities, limitations on their practice, and supervision of their services by qualified physicians.

(2) That the AMA reaffirm the principle that the basic responsibility for the care and welfare of patients lies with their physicians of record and that that responsibility cannot and should not be delegated.

(3) That the Association's Law Division assist the state medical societies in identifying and avoiding any legal hazards that may accompany the employment of doctors' assistants.

Premise No. 8:

There is a major interest in the delivery system for health care. Rather than support particular kinds of organization and payment for health services and oppose others, the AMA should devote its energies to establishing the criteria by which they are judged.

Recommendations:

(1) That the Association take no public position for or against private solo practice, private group practice, closed panel group practice, fee-for-service payment, or prepayment by capitation.

(2) That an appropriate committee of the AMA be charged with the task of establishing the basic criteria which any proposed system of delivery of health services or mechanism for payment must satisfy to be acceptable.

(3) That the Association, in all public statements, emphasize the concept that differences in education, culture and income levels create problems that may necessitate different systems of delivering medical care for different population groups.

(4) That the state and local medical societies be encouraged and assisted in devising and proposing practice expedients suited to their localities and their problems.

(5) That the Association, in conjunction with the state and county medical societies, establish a consultation and assistance service for physicians or groups of physicians who wish to develop organizations or programs for the rendering of health services.

(6) That the AMA endeavor to be informed of the pilot projects that are proposed by other sources and that it request the Department of HEW to discuss those projects with the Association before they are put into effect.

(7) That the Association seek to insure that the value judgments made by the Department of HEW on plans, programs, pilot projects and payment mechanisms are firmly based on the criteria and standards the AMA has developed for that purpose.

continued on next page

Named to WRMP Board

The State Medical Society's president-elect, Dr. Jerry W. McRoberts of Sheboygan, on Nov. 4 was named to the Board of Directors of the Wisconsin Regional Medical Program, Inc.

He succeeds Dr. Frank E. Drew of Milwaukee who resigned.

PROPOSED REVAMP OF AMA POLICIES AND PROGRAM
continued

Premise No. 9:

Fee negotiations do not fall within the province of the AMA but the AMA could very well serve a useful function at the federal level by negotiating all other aspects of tax-supported health programs. It must, therefore, have access to data, the availability of which would assist state and local societies in their discussions with government.

Recommendations:

(1) Urge state medical associations to undertake various studies, including surveys of prevailing medical fees.

(2) Develop a uniform methodology for conducting such studies to the end that the data from the various states and localities be comparable.

(3) Serve as a clearing house for the material thus obtained and, after analysis, redistribute the data to the state medical associations with suggestions and conclusions.

(4) Urge the state medical associations to designate negotiators who are qualified to deal energetically with government agencies on all matters pertaining to tax-supported programs. Such individuals or groups should be formally appointed and the government jurisdiction involved should be notified that all negotiations will be conducted by them.

Premise No. 10:

The medical profession must now decide whether it is prepared to meet the obligation it has accepted for cost control through the monitoring and containment of fee levels.

Recommendations:

(1) That the AMA urge state and county medical societies to assume the functions of monitoring fees and containing the costs of health care.

(2) That the Association, in cooperation with the constituent societies, determine what powers the state and local societies require to serve these functions and how those powers can be best obtained.

Premise No. 11:

The medical profession must accept obligations for medical audit to assure that tax-supported programs are paying for services of acceptable quality. At the same time, it must develop improved programs of postgraduate study.

Recommendations:

(1) Endorse the principle of voluntary, life-long post-graduate study for all physicians and continue and accelerate the development of programs and incentives for such study.

(2) Through the state medical societies, investigate the current status of in-hospital audit methods and make a similar investigation of the state of development of the evaluation of office services.

(3) Encourage and assist the state medical societies and state departments of health and welfare to develop uniform and effective methods of audit for both office and in-hospital services, based on electronic data processing, to the maximum possible extent.

(4) Request the Law Division to clarify the extent to which a physician's responsibility for the privacy of his patients' records will permit him to cooperate in an audit of his office practice.

Premise No. 12:

To prevent the development of a double standard for licensure (one for authority to serve private patients and another for those patients under tax-supported programs), it would seem preferable to revise the state education laws or, better yet, to develop a national professional education law that would modernize and update undergraduate, graduate and postgraduate requirements.

Recommendations:

(1) That the AMA encourage and assist all state medical associations to devise programs for voluntary postgraduate study designed to maintain medical education at an optimum level and to be least disruptive to the provision of medical services.

(2) That the Association obtain information from each state medical society as to whether special requirements have been imposed on physicians who render services to patients under the provisions of tax-supported programs and obtain the specifics of what those requirements are.

(3) That in those states where the health or welfare departments have imposed special requirements on physicians to participate in their programs, the medical society reject those requirements and that, if the need for such regulation can be demonstrated, the state medical society, education department, and health department cooperatively develop standards to be incorporated into the education law and enforced on all physicians of that state, thereby eliminating double standards for medical practice and restoring the licensing authority to the proper agency.

Premise No. 13:

New ways need to be found to resolve hospital bed shortages, apply utilization review procedures and regularize the complex relationships between physicians and hospitals.

Recommendations:

(1) That the Association secure data from state and county medical societies on problems in physician-hospital relationships in their areas and the measures, if any, that are being taken to solve them.

(2) That, on the basis of these data, the Association identify the basic principles that apply to staff-hospital relationships and encourage state and county medical societies to do the same.

(3) That the Association and each state and county medical society request its counterpart in the

hospital association structure to assist in developing guidelines and urge their member associations and hospitals to implement them.

Premise No. 14:

The stresses on the present health care system call for new and imaginative approaches to the utilization and distribution of our total pool of resources in terms of manpower, facilities and money.

Blue Cross, Blue Shield, and the AMA have a joint interest which calls for them to close ranks and coordinate their efforts if voluntary systems are to survive.

Recommendations:

(1) That the Association, through its current liaison with the NABSP, seek to obtain continuous and current information on the Medicare Program; that it secure data on the development of additional benefits, new fields of coverage, and minimum standards of benefits in voluntary plans; and that, through the NABSP, it stimulate the Blue Shield Plans to greater efforts in upgrading their programs.

(2) That a similar liaison committee be developed in conjunction with the Blue Cross National Association for similar purposes.

(3) That the AMA advise state and county medical societies to take similar action at their respective levels and to review their representation on the boards of directors of their local Blue Plans to be sure that their representatives are individuals who are currently active in society affairs and familiar with society policy.

(4) That the Association seek a formal and direct channel of communication with the Department of Health, Education, and Welfare, with the object of developing its own capacity for modifying existing and new programs when such modification is indicated, rather than relying solely on the NABSP for this purpose.

Premise No. 15:

It is necessary to evaluate all health care services in terms of their importance, urgency, and cost effectiveness and to establish minimum standards and priorities on that basis. There is a need for identifying both short-term and long-term goals in health care for all individuals to serve as a yardstick to measure the adequacy and progress of voluntary health insurance programs.

Recommendations:

(1) An appropriate committee or division of the Association gather information from the state medical societies on the availability of physicians, ancillary personnel, hospital beds in all categories, laboratories, public health nurses, social service workers, and all other types of health professionals.

(2) The Association promulgate a "Health Bill of Rights" to identify the services that comprise comprehensive health care.

(3) On the basis of the data obtained from the state medical societies, the Association establish minimum standards for health care and a system of priorities for the provision of services beyond those minima, thus creating both an immediate and a long-range schedule for their attainment.

(4) The Bill of Rights, the data and the standards and priorities receive wide publicity.

Premise No. 16:

More attention should be given to the manner in which the medical profession, through the medical societies and the AMA, relate to regional medical programs and comprehensive health planning (Public Law 89–239 and Public Law 89–749).

Recommendations:

(1) That the Association request the state medical societies to submit information on the status of comprehensive areawide planning in their states and the problems that are being encountered.

(2) That this information be analyzed, summarized, and redistributed to the state societies, together with the suggestions made in the preceding paragraph and a resumé, prepared by the Law Division, of the provisions in the law that are pertinent to those suggestions.

continued on next page

THE WISCONSIN DELEGATION TO THE AMA . . . gathers on the floor of the House of Delegates at Denver, Dec. 2. (L to R): Dr. Gunnar Gundersen, La Crosse, past president of the AMA who stopped to visit with the delegation; Dr. John M. Bell, Marinette; Dr. R. E. Galasinski, Milwaukee; Dr. W. B. Hildebrand, Menasha; Dr. E. L. Bernhart, Milwaukee, and Dr. C. J. Picard, Superior. Just prior to the picture-taking, the delegation had presented Dr. Gundersen with a personal copy of the Gundersen Festschrift issue of the *Wisconsin Medical Journal*.

PROPOSED REVAMP OF AMA POLICIES AND PROGRAM
continued

(3) That the implementation of comprehensive areawide health planning be reviewed periodically and that the state and county medical societies be advised of the problems and pitfalls in this difficult but important area of endeavor.

Premise No. 17:

A substantial section of the report is devoted to an analysis of the structure of the AMA and an evaluation of how suitable that structure is to effect the attainment of the Association's objectives in light of the forces at work in society today.

Recommendation:

That the present structure of the Association be retained and that it be strengthened by improvements and modifications in its function.

Premise No. 18:

AMA must assume leadership in bringing about the expansion and reorganization of state and county societies for the purpose of gathering and analyzing data relating to health care and for greater coordination of the units of organized medicine while retaining more individual identities and purposes.

Recommendations:

(1) That an immediate survey be conducted of the state medical societies and, through them, of the component county medical societies to determine what arrangements they have made, if any, for the regular collection of data on the socio-economics of health care.

(2) That, on the basis of the information received, the AMA develop tables of organization for research divisions at the state levels and methods of participation for county societies that are in keeping with their resources. The planning should be developed along lines that are compatible with the concept of a tight federation of societies and are least disruptive to research divisions that are already in existence.

(3) That the plans and tables of organization in their initial form be circularized among the state and county medical societies with the reasons for their development and strong recommendations for affirmative action.

(4) That the association hold a series of working meetings with state and county medical society executives, individually or in groups, to further refine the organizational patterns and procedures that will best serve them in this collective endeavor.

Premise No. 19:

Mere possession of information is not enough. There must be internal mechanisms for analyzing data, identifying problems and recommending policy.

Recommendation:

That on implementation of the program for organization and reorganization, a planning council with appropriate subcommittees be formed for the purpose of processing data and formulating policy recommendations for the consideration of the Board of Trustees and the House of Delegates.

Premise No. 20:

No single professional group can influence the public or government on any aspect of health services. The health professional organizations together could have a very weighty influence. It seems logical for them to unite in a formal organization to play their part in the planning, legislation, and delivery of health services, a goal they cannot achieve individually.

Recommendation:

That the AMA sponsor, promote the formation of, and participate in, a "National Academy of the Health Professions for Research and Policy."

Premise No. 21:

The academy must have certain specific characteristics and relationships with its sponsors.

Recommendations:

One Possible Structure for the Academy

(1) That it be a non-profit membership corporation with the sponsoring professional associations as members;

(2) That the member organizations be limited to (a) national associations in the fields of medicine, nursing, dentistry, osteopathy, medical education, hospital administration, health and hospital insurance; (b) national associations representing ancillary workers, such as optometrists, psychologists, pharmacists, and laboratory and x-ray technicians; and (c) national public health agencies.

(3) That the academy have a board of directors numbering approximately forty or fifty members, drawn from the participating organizations partly on the basis of their membership. It is obvious, however, that the number of members alone is not a sufficient criterion to determine representation since the different health professions do not exert the same influence over the planning, delivery, and cost of health care. It will therefore be necessary to apply an additional weight or factor to the various organizations in determining their representation on the board of directors. This may well be the subject of negotiation.

(4) That initially the directors be appointed by their respective member professional associations for terms of one, two, and three years, so that the board will ultimately consist of three classes of directors, each serving terms of three years.

(5) That tenure on the board of directors be limited to three terms or 10 years.

(6) That the board of directors elect a chairman from among its members triennially and that he be paid a salary commensurate with the claims made on his time and effort.

(7) That a voting member group be organized for the purpose of

electing directors once the first, appointed directors have served their terms. The voting member group should be composed of sixty to seventy-five individuals, thirty-five to fifty of them to be distributed among the sponsoring agencies in a proportionate manner, with the remaining number to be chosen from interested branches of government and appropriate individuals from the public at large.

(8) That each year a slate of nominees for directors be proposed by a nominating committee of the board of directors and that further nominations, if any, be made from the floor at the annual meeting by any single member of the voting member group.

(9) That the directors not be employees, active officers, or trustees of their own professional associations.

(10) That the academy retain an executive officer and indicated supportive staff on a full-time salaried basis.

(11) That there be the usual division of function and responsibility between the executive officer and the board of directors.

Premise No. 22:

The academy shall have as its purposes and functions the collection of data relating to health care and identification of weaknesses and deficiencies in health services and the ability to relate them to available funds, facilities and personnel to develop specific, practical solutions on a priority basis.

Recommendations:

The following is a partial list of the academy's areas of interest, research, and study:

(1) Distribution of health care personnel—deficiencies in number and type by areas.

(2) Distribution and adequacy of health care facilities by area, to include hospitals, hospital based or free standing clinics, extended care facilities, home care services, and clinical laboratory services.

(3) Costs, to include medical and other professional fees by area or region, hospital and extended care facility rates, charges for other services, drugs, and sick room supplies.

(4) Available health insurance programs, cash or service indemnity, scope of benefits, completeness of coverage, cost.

(5) Delivery mechanisms by area, private solo practice, fee-for-service group practice, prepaid group practice, hospital practice in-hospital and clinic, full or part-time.

(6) Morbidity and mortality statistics by area or region.

(7) Professional education and training at the undergraduate, graduate, and postgraduate levels.

Staff, funding and pros and cons for the academy are also provided in the report.

The members of the Committee on Planning and Development which prepared and presented their findings to the House of Delegates were:

George Himler, MD, Chairman, New York, N.Y.

George F. Brockman, III, MD, Greenville, Ky.

John H. Budd, MD, Cleveland, Ohio

G. Baker Hubbard, MD, Jackson, Tenn.

John H. Knowles, MD, Boston, Mass.

Eugene S. Rifner, MD, Van Buren, Ind.

Malcolm S. M. Watts, MD, San Francisco, Calif.

The Committee was discharged having served its function and report and a new ad hoc committee on long-range planning and development was authorized by the House of Delegates to prepare reports and receive recommendations on how best to proceed.

This committee will report at the June 1970 meeting of the AMA House of Delegates in Chicago.

Individual physicians and county and state medical societies are urged to submit their comments and recommendations concerning the long-range planning and the so-called "Himler" report no later than May 1, 1970. □

Kastenmeier's Assistant Praises PACE

"PACE is a good idea. I think it can be better and it can be more effective." Those were the remarks of Kaz Oshiki, administrative assistant to Second District Congressman Robert Kastenmeier, when he addressed the fall session of the Professional Association for Civic Education (PACE) in Minocqua.

Oshiki complimented the PACE board of directors for its willingness and enthusiasm in becoming involved in the processes of government and strongly advocated that citizens from all walks of life, the professions, labor, and industry, continue to initiate and support the political action committee concept among their respective memberships.

During an informal, but spirited discussion, Oshiki pointed out that PACE is in an excellent position to serve the medical profession by listening to and taking action on physicians' deliberations regarding candidates and issues. He concluded by urging the Board to open meaningful, effective lines of communication between doctors of medicine and the representatives whom they have helped to elect.

PACE is a Wisconsin, voluntary, nonprofit association dedicated to improved government through civic education for effective political action.

continued on next page

KAZ OSHIKI, administrative assistant to Congressman Kastenmeier, and Dr. H. J. Kief of Fond du Lac, chairman of PACE board of directors, chat at the association's fall session recently.

Nels A. Hill, MD; F. B. Henderson, DDS; William J. O'Rourke, DVM; and Rockne G. Flowers, CPA

Scott Cutlip and W. D. James, MD

Program Is Outlined to Update Professionals

A program to assist and reward doctors, lawyers, engineers, and other professional people trying to stay abreast of their field was explained at a recent meeting of the Wisconsin Association of Professions, held at the State Medical Society Headquarters.

Dean Kurt Wendt, College of Engineering, University of Wisconsin, told the group that changes are occurring at ever-increasing rates in all professions. "Nearly 80% of the medications used today were unknown 10 years ago," he said. Engineers may have lost or forgotten half of their ability within five years of graduation, if they do not continue to study or learn anything new on the job.

He discussed the University's Professional Development Degree Program, approved by both faculty and regents and awaiting final approval by the Committee for the Coordination of Higher Education. It would credit knowledge learned at institutes, seminars, and other professional meetings. Instead of merely attending these meetings, an individual would have an opportunity to earn credits by passing examinations of his new knowledge.

It is believed that this program would enable two-thirds of all college graduates ineligible for graduate study to further their professional careers. The program could be tailored to any field.

Professor of Journalism, Scott Cutlip, stressed the professions' need for better public relations, defined as "the planned effort to influence opinion through socially responsible performance." This is based on two-way communication.

Stresses produced as the country changed from a society of small towns and face-to-face relationships to a society of large urban centers and impersonal relationships have resulted in a "fluid, mobile society of over-powering bigness, impersonality, and interdependence, one dominated by technology and troubled by conflict."

"There is a nostalgic yearning for the touch of the country doctor today," Cutlip continued. "Your patients don't want to be a patient number any more than our students want to be an IBM number."

It is important for the professional person to assist individuals in adjusting to change caused by the complexities of society, as well as being competent in skills, he said.

To Clarify a Situation . . .

SMS has been informed that several county medical societies have been approached by the Community Health Research Group of the Ohio State University concerning a pre-school nutritional survey.

Physicians should be aware that there is no affiliation or association between the College of Medicine of Ohio State University and the Community Health Research Group.

PACE *continued*

The Board is composed of Dr. H. J. Kief, Fond du Lac, chairman; Dr. Gunnar Gundersen, La Crosse, honorary chairman; Dr. DeLore Williams, Milwaukee, vice-chairman; Mrs. W. D. James, Oconomowoc, vice-chairman and treasurer; and Paul A. Weise, Waterloo, secretary.

District representatives on the Board: Drs. John L. Babb, Beloit, and William E. Fraser, Kenosha (1st); Dr. Marvin G. Peterson, Lake Mills (2nd); Drs. Fred Wolf, La Crosse, and Charles L. Steidinger, Platteville (3rd); Dr. Gregory Inda, Milwaukee (4th); Dr. James A. Schelble, Milwaukee (5th);

Dr. Paul Wainscott, Menasha (6th); Drs. Roy B. Larsen and Kenneth L. Day, Wausau (7th); Dr. E. George Nadeau, Jr., Green Bay (8th); Dr. James V. Bolger, Jr., Waukesha (9th); and Drs. M. L. Whalen, Bruce, M. W. Asplund, Bloomer, and Robert M. Anderson, Cumberland (10th).

Mrs. Max Smith of Madison is a member-at-large.

Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.

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SECTION OPHTHALMOLOGY

MEDICINA NUSQUAM NON EST

STATE MEDICAL SOCIETY OF WISCONSIN

DECEMBER 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

DR. GILLER ADDRESSES MADISON GROUP

Dr. Herbert Giller, Milwaukee, spoke to the Madison Chapter of Hadassah at its annual eye bank luncheon in November at Temple Beth El in Madison.

RESIDENTS AT MADISON GENERAL HOSPITAL

The University of Wisconsin residency program has been expanded to include Madison General Hospital, Madison's largest private hospital. There is now one third-year ophthalmology resident at Madison General Hospital full time and he is rotated every three months. The rotation to Madison General Hospital comes after this senior resident has completed his surgical rotations at Veterans Administration Hospital and University Hospitals in Madison. Dr. John Berger, Madison, is director of the Madison General Hospital program.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

Dr. Mansour Armaly of the University of Iowa, Iowa City, spoke Nov. 25 before the Milwaukee Ophthalmological Society. The next meeting of the Society will be Jan. 27, 1970. The program will be arranged by the University of Wisconsin.

WISCONSIN LIONS EYE BANK REPORT

The Wisconsin Lions Eye Bank Committee recently held a meeting to receive reports of the Milwaukee and Madison Eye Banks.

For the period July 1 to Sept. 1, 1969, there were 20 eyes donated to the Milwaukee Eye Bank. Six were used as transplants, two were preserved, and 12 were used for research.

For the period July 1 to Oct. 27, 1969, there were 32 eyes donated to the Madison eye bank. Twenty were used for transplant and 12 were used for research.

Not all of the eyes used for transplant were used locally as some were distributed nationally via the Eye Bank Radio Network.

JUNIOR WISE OWL CLUB

In the continuing search for ways and means to encourage eye safety, the National Society for the Prevention of Blindness and its affiliate, the Wisconsin Society for the Prevention of Blindness have established a Junior Wise Owl Club. This club is open to youths who have saved their sight by wearing safety eye glasses or other types of eye protection at the time of a potentially blinding accident. This club is an expansion of the internationally known Wise Owl Club of America, established in 1948 for the purpose of reducing needless and costly industrial eye accidents and loss of sight by encouraging the widespread use of proper eye-protection equipment.

WISCONSIN SOCIETY FOR THE PREVENTION OF BLINDNESS

The annual meeting of the Wisconsin Society for the Prevention of Blindness was held Nov. 6 at the University Club in Milwaukee.

Wisconsin ophthalmologists are encouraged to join the Wisconsin Society for the Prevention of Blindness which is an affiliate of the National Society for the Prevention of Blindness. The address is 312 East Wisconsin Avenue, Milwaukee, Wis. 53202.

Dr. Ralph E. Teitgen, Milwaukee, chairman of the Section on Ophthalmology of the State Medical Society of Wisconsin, is medical advisor to this organization.

DR. DAVIS LECTURES IN CLEVELAND

Dr. Matthew Davis of Madison was a guest lecturer at the annual conference of the Cleveland Clinic Ophthalmology Department Dec. 10 and 11 in Cleveland, Ohio. Theme of the meeting was "Concepts in Diagnosis and Management of Diseases of Vitreous, Retina, and Choroid."

VOLUNTARY DUES ASSESSMENT

The Executive Committee reminds all ophthalmologists that voluntary dues for the year **1969** are still being received. Voluntary contributions to the Section are used for projects specially designed to educate the public and others on medical eye care.

The regular voluntary membership contribution is $100. Educational membership contribution, for physicians who derive no part of their income from private practice, is $50.

Please make your check payable to the Section on Ophthalmology, Box 1109, Madison, Wis. 53701.

NEWS HIGHLIGHTS

Hundreds Honor "Doc" Freymiller

Sunday, Nov. 9, was a very special day in the life of Dr. E. F. Freymiller* and his wife of Boscobel. It was "Doc" Freymiller Day.

Having served the Boscobel community for 39 years, the beloved family physician and "friend to everyone" was honored with a parade and special program in the high school gym, sponsored by the Chamber of Commerce.

Dr. E. M. Randall,* associate of Doctor Freymiller at the Boscobel Clinic, was master of ceremonies, and Dr. H. W. Carey* of Lancaster, president of the Grant County Medical Society, was a guest speaker.

AN OLD FRIEND, retired banker John Ruka, presented Dr. E. F. Freymiller (seated) with a check for $1,103, representing cash gifts from more than 250 families, during the "Doc" Freymiller Day festivities. (Photo courtesy BOSCOBEL DIAL)

Doctor Freymiller is a native of Grant County, and graduated from Fennimore High School in 1912.

After service in the Army he received his medical degree from the University of Wisconsin in 1922. He practiced in Minnesota until coming back to the Boscobel area in 1930.

Doctor Freymiller has served his community in many capacities besides his profession—as a Boy Scout supporter, church worker, and civic leader. He is still active despite a hip condition that requires use of two canes.

Dr. Chojnacki Named VP of Interstate

Dr. S. L. Chojnacki* of Milwaukee was named one of three vice-presidents of the Interstate Postgraduate Medical Association at its 54th Annual Scientific Assembly in Cleveland Oct. 13–16. Doctor Chojnacki is a councilor of the State Medical Society.

Wisconsin trustees of Interstate are: Drs. John H. Bell,* Marinette; William B. Hildebrand,* Menasha; and N. Alfred Hill,* Madison.

Dr. Leonard L. Lovshin of the Cleveland Clinic presided at the Assembly. He is a graduate of the University of Wisconsin Medical School, Madison.

Dr. Morris Fishbein of Chicago was named president-elect of the Association.

Dr. George Kerr Speaks

Members of the Winnebago County Medical Society on Oct. 2 heard Dr. George Kerr of the University Hospitals, Madison, speak on the "Pediatric Endocrinologist."

PHYSICIAN BRIEFS

Dr. Benedict Polcyn

. . . has joined Dr. Raymond J. Rogers* as pathologist for Marinette General Hospital and St. Joseph–Lloyd Hospital of Menominee. They will also serve Oconto Memorial Hospital and the Upper Peninsula Cytology Laboratory in Menominee. Doctor Polcyn graduated from the University of Michigan Medical School in 1952 and served his internship and residency at Columbia Hospital in Milwaukee. He had been a pathologist at Aurora, Ill., before moving to Marinette.

Dr. John P. Layde

. . . has joined the medical staff of the Midelfort Clinic, Eau Claire, in the pediatrics department. He graduated from Northwestern University Medical School and served a two-year residency in pediatrics at the University of Tennessee Medical Center, Memphis. Doctor Layde also had additional training in pediatric endocrinology and metabolism at the University of Tennessee.

Dr. B. H. Dessel*

. . . Wood, was the guest speaker at a meeting held at the Marshfield Clinic which was sponsored jointly by the Wisconsin Hematology Study Group and the Marshfield Clinic Foundation. "The Management of Hodgkin's Disease" was the subject of the meeting.

Dr. K. L. Matson

. . . former surgical instructor at the University of Illinois Medical School, recently joined the medical staff of the Shell Lake Clinic and the Indianhead Memorial Hospital.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Dr. Robert L. Kalember

. . . Janesville, recently joined the staff of the Pember–Nuzum Clinic, Janesville. He graduated from the University of Michigan Medical School and served his internship at St. Mary's Hospital, Grand Rapids, Mich. Doctor Kalember completed a three-year residency in psychiatry at the Mental Health Institute, Independence, Iowa.

Dr. Albert J. Coron*

. . . Watertown, recently opened offices in the Fox Lake Medical Center, Fox Lake and will be seeing patients there one day a week. Fox Lake has been without a physician for the past three years. Doctor Coron graduated from the University of Wisconsin Medical School and served his internship at the Milwaukee Columbia Hospital. He also has offices in Watertown and Milwaukee.

Dr. Albert F. Rogers*

. . . recently was named president of Oconomowoc Memorial Hospital medical staff. Also elected were Dr. Richard K. Chambers,* Hartland, vice-president; and Dr. G. Daniel Miller,* Oconomowoc, secretary-treasurer. Drs. John D. Wilkinson* and Dean P. Epperson,* Oconomowoc, and Richard F. Hearn, Milwaukee, were elected to the executive committee.

Dr. Helen Jane Zillmer*

. . . Milwaukee pediatrician, in October received the 1969 Pro Urbe medal from Mount Mary College along with two other civic leaders. The medal named "for the city" is given each year in recognition of civic and cultural contributions. Doctor Zillmer retired this year after 49 years of service to Milwaukee Children's Hospital.

Dr. Philip T. Eckstrom*

. . . Marinette, recently was elected a member of the American Academy of General Practice.

Three Physicians Join Gundersen Clinic

Three physicians have recently joined the Gundersen Clinic and La Crosse Lutheran Hospital staffs in La Crosse.

Dr. Cornelius A. Natoli, a native of Utica, N. Y., has joined the Department of Urology. He obtained his MD degree from Georgetown University School of Medicine, Washington, D. C., in 1956.

A surgical internship was completed at Barnes Hospital, St. Louis, Mo., followed by a year of surgical residency and three years of urology residency at the same hospital.

From 1961 to October 1969 Doctor Natoli was in private practice of urology in Salt Lake City, Utah. In 1965 he was certified by the American Board of Urology and is also a fellow of the American College of Surgeons.

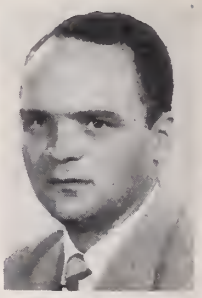
Dr. Jerome H. Gundersen,* a native of La Crosse, is associated with the Department of Obstetrics and Gynecology. He graduated from Harvard University, Cambridge, Mass., in 1958 and obtained his MD degree from the University of Wisconsin Medical School in 1962.

Dr. Natoli

Doctor Gundersen served his internship at the Chicago Wesley Memorial Hospital from 1962 to 1963. From 1963 to 1967 he fulfilled his residency training at the Chicago Wesley Memorial Hospital, Northwestern Gynecological Pathology Laboratory, and the Chicago Maternity Center. He served with the United States Air Force from 1967 to 1969.

Dr. Glenn M. Seager, a Vermont native, is associated in the Ear, Nose, and Throat Department. He received his BS and MD degrees at the University of Vermont before serving his rotating internship at the Robert Parker Hospital in Sayre, Pa., from 1959 to 1960. He then spent one and one-half years at the Cleveland Clinic in Ohio and two and one-half years at the University of Vermont Affiliated Hospitals in Burlington as a resident in otolaryngology in 1964.

Dr. Seager



Dr. Gundersen

Doctor Seager was a full-time instructor and then tenured assistant professor at New York University Bellevue Medical Center in New York City for the next three years.

He served with the U.S. Army for two years, as a captain and then as a major at Madigan General Hospital in Tacoma, Wash. He also was a part-time assistant professor at the University of Washington School of Medicine in Seattle during that time.

Dr. Aster, New Director, Milwaukee Blood Center

Dr. Richard H. Aster has been appointed executive director of the Milwaukee Blood Center. In addition, he will join the faculty of Marquette School of Medicine. An assistant professor of medicine at Harvard Medical School and research associate at Thorndike Memorial Laboratory in Boston, Doctor Aster is a medical graduate of the University of Michigan. He currently holds a National Heart Institute grant for research on platelet physiology, platelet transfusion, and the immunology of platelets and leukocytes.

UW Med Student Honored

John Rank, a junior in the University of Wisconsin Medical School, Madison, was given the Rasey Memorial scholarship at the 50th annual meeting of the Wisconsin Farm Bureau Federation Nov. 15–18 at Lake Delton. The cash award is given annually to a deserving medical student.

Dr. Salan Heads Waupaca Society

Dr. Jerry R. Salan* of Waupaca was elected president of the Waupaca County Medical Society at its September meeting in New London. He succeeds Dr. William G. Arnold* of Clintonville.

The new vice-president is Dr. Lloyd P. Maasch* of Weyauwega. Dr. Joseph W. Weber* of New London was reelected secretary-treasurer.

Dr. John H. Steiner* of Waupaca was reelected to another three-year term as a trustee of the State Medical Society's CES Foundation.

During the business session members discussed the utilization committee at Iola Hospital.

Dr. Stovall Addresses Waupaca Society

Changing trends in medical education and what the University of Wisconsin is doing to meet the needs of the state were discussed by Dr. William D. Stovall,* special assistant to the dean of the University of Wisconsin Medical School, Madison, at the Nov. 4 meeting of the Waupaca County Medical Society.

On Nov. 20 a special meeting of the Society was held at which time the guest speakers were Drs. Mielke and Ryan who talked on the coronary care unit.

Physicians Speak at Cancer Conference

Four Wisconsin physicians were featured speakers at the Regional Nursing Conferences co-sponsored by the American Cancer Society, Wisconsin Division, and the University of Wisconsin, department of nursing extension, held at Rhinelander on Nov. 18 and at Fond du Lac on Nov. 20.

Dr. Warner S. Bump* and Dr. John Brown* of the Warner S. Bump Medical Group in Rhinelander, Dr. Fred Ansfield* of the University Hospitals in Madison, and Dr. Norman O. Becker* of Fond du Lac were participants.

Dr. Patricia Novak

. . . and Dr. Horace Frank, recently accepted appointments to the medical staff of the Tomah VA Hospital. Doctor Novak, a native of Ireland, attended the National University Medical School, Galway, Ireland, and graduated in 1957. She was in private practice in Norwalk, Conn., before joining the VA hospital. Doctor Frank graduated from the Louisiana State University Medical School. He served a rotating internship at St. Joseph's Hospital in Marshfield and has been in private practice with visting staff hospital appointments at the Neillsville Hospital and St. Joseph's Hospital in Marshfield.

Dr. R. S. Pavlic*

. . . Brookfield, recently was the guest speaker at the Menomonee Falls Woman's Club. Doctor Pavlic spoke on "The Power and Purpose of Sex." He is chairman of the department of obstetrics and gynecology of Elmbrook Memorial Hospital.

Announcing THE THIRTY-THIRD ANNUAL MEETING OF

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—The Roosevelt Hotel—March 2, 3, 4, 5, 1970

GUEST SPEAKERS

John J. Bonica, M. D., Seattle, Wash
ANESTHESIOLOGY

John R. Hill, M. D., Rochester, Minn.
COLON AND RECTAL SURGERY

Walter B. Shelley, M. D., Philadelphia, Pa.
DERMATOLOGY

H. M. Pollard. M. D., Ann Arbor, Mich.
GASTROENTEROLOGY

Walter Lane, M. D.. Tampa, Fla.
GENERAL PRACTICE

Henry Clay Frick, II, M. D., New York, N. Y.
GYNECOLOGY

William H. Crosby, M. D., Boston, Mass.
INTERNAL MEDICINE

Thomas L. Petty, M. D, Denver, Colo.
INTERNAL MEDICINE

David N. Danforth, M. D., Chicago, Ill
OBSTETRICS

Jack A. Dillahunt, M. D., Albuquerque, N. M.
OPHTHALMOLOGY

John J. Niebauer, M. D., San Francisco, Calif.
ORTHOPEDIC SURGERY

William K. Wright, M. D, Houston, Tex.
OTOLARYNGOLOGY

Omer E. Hagebusch, M. D., St. Louis, Mo.
PATHOLOGY

Chester M. Edelmann, Jr., M. D., Bronx, N. Y.
PEDIATRICS

Howard P. Rome, M. D., Rochester, Minn.
PSYCHIATRY

Wendell P. Stampfli, M. D., Denver, Colo.
RADIOLOGY

Joel W. Baker, M. D., Seattle, Wash.
SURGERY

Edwin J. Wylie, M. D., San Francisco, Calif.
SURGERY

Ralph A. Straffon, M. D., Cleveland, Ohio
UROLOGY

Lectures, symposia, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives.

(All-inclusive registration fee—$35.00)

This program is acceptable for twenty-two (22) prescribed hours and nine (9) elective hours by the American Academy of General Practice.

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Dr. Donald H. Martin*

. . . Milwaukee psychiatrist, recently discussed drug addiction with students at Cardinal Stritch College. Doctor Martin is affiliated with the department of psychiatry at Marquette School of Medicine.

Dr. Joseph Springer*

. . . has returned to his practice in Durand after spending nearly one year in a new medical clinic in an economically depressed area of northern Mississipi. The public service stint was sponsored by a Tufts University project.

Dr. Eugene Eckstam*

. . . of The Monroe Clinic has developed a scientific exhibit entitled "Indications for Esophago-Gastrocamera Studies," which he presented at the recent annual meeting of the Wisconsin Academy of General Practice held in Madison. Developed in Japan in 1950, the miniature camera takes photos of the stomach to determine the presence of ulcers and cancer. It was first introduced in this country in 1962 by Dr. John Morrissey* of the University of Wisconsin. Since that time Doctor Morrissey has taught the technique to about 20 doctors a year —including Doctor Eckstam who received his training early in 1969. The tiny camera has already been used in 80 cases at The Monroe Clinic. Currently these cameras are being used in only five Wisconsin cities—Marshfield, Sheboygan, Milwaukee, Madison, and Monroe. Doctor Eckstam plans to take the exhibit to the State Medical Society's annual meeting next May in Milwaukee.

Drs. H. J. McLane*

. . . and Donald A. Smith, Fond du Lac, recently spoke at a public forum on arthritis in Fond du Lac. The forum is part of a statewide program that seeks to "bring the facts about arthritis to the people who have it particularly and to the public in general," according to Dr. J. M. Meyer,* Milwaukee, president of the Wisconsin Arthritis Foundation.

Norway Physician Joins Research Program at Gundersen Clinic

A neurophysiologist at the Gaustad Sykehus Vinderen in Oslo, Norway, is combining his research activities with Dr. C. Norman Shealy* of the Gundersen Clinic in La Crosse on various aspects in the treatment of Parkinson's disease.

Announcement of the joint research venture was made in late October when Dr. Carl W. Sem-Jacobsen, a pioneer in the field of space medicine, visited the Gundersen Clinic staff after attending a meeting of the American Society of Astronautics and Aeronautics in Los Angeles.

The amiable Norwegian has been connected with the U.S. space program since 1957. One of his assignments included examinations of Neil Armstrong, first man to set foot on the moon.

Dr. Sem-Jacobsen is an expert in the field of electroencephalography. Doctor Shealy, who is chief of the Gundersen Clinic's Department of Neuro–Science, has done extensive work in the diagnosis and treatment of brain injuries and diseases such as parkinsonism, using electronic devices.

The two physicians hope to work together in finding ways to improve man's knowledge of how the brain works and to develop, refine, and merge their respective techniques in the diagnosis and treatment of brain and spine injuries and disease.

The two hope someday to establish an exchange program whereby teams of specialists from Doctor Sem-Jacobsen's Norwegian clinic would come to the Gundersen Clinic for study and work, and Gundersen Clinic neuro–science specialists would go to Oslo for the same reasons.

Doctor Sem-Jacobsen had something of a reunion during his visit in La Crosse. He met two countrymen, Drs. Rolv Slungaard* and Kaare Getz,* who are both on the Gundersen Clinic staff. The trio left Norway and did advanced study together at the Mayo Clinic, Rochester, Minn., from 1951–1955.

DR. CARL W. SEM-JACOBSEN (left) of Osla, Narway, and Dr. C. Narman Shealy af the Gundersen Clinic, La Crosse, at a recent press canference annaunced plans to coaperate in a research project that involves variaus aspects in the diagnosis and treatment of brain-injured patients.

Speed Queen Helps Ripon

The Speed Queen Corp. recently donated $3,000 to DOC, Inc., a Ripon doctor recruitment corporation. The grant will help produce a brochure that will feature Ripon's present and future medical facilities, educational assets, recreation, economic conditions, prospects for business growth, government, and community facilities. The brochures will be mailed to prospective doctor candidates.

Doctors in Heart Program

Dr. Thorn Vogel,* Janesville health commissioner, and Dr. Ernest Deeds,* an internist with the Pember Nuzum Clinic in Janesville, addressed a public audience on current heart surgery and heart disease prevention early in November. The program was sponsored by the Wisconsin Heart Association in cooperation with the Vocational District 5.

In-Depth Teaching Programs

On page 11 of this issue are listed the in-depth teaching programs of the State Medical Society and University of Wisconsin.

Dr. Urben, Mendota Supt., Will Retire

After serving 21 years as superintendent of Mendota State Hospital in Madison, Dr. Walter J. Urben* will retire in March.

During Doctor Urben's tenure, improvements in patient care and treatment and in hospital facilities have made Mendota one of the outstanding state hospitals in the country.

Under Doctor Urben's leadership the hospital has become a training facility for psychiatrists, nurses, social workers, theology students, and other professionals represented on the staff. In addition it was one of the first in the country to open its doors to the community and the participation of volunteers in the hospital program.

Dr. Urben

In 1948, when Doctor Urben was named superintendent, only four or five physicians were available to treat more than 800 patients. All were housed in a single, large structure. This has since been replaced by modern patient buildings. Today, the hospital has about 670 patients who are served by a medical staff of 31.

Doctor Urben also has contributed greatly toward the development of mental health programs in Wisconsin and has worked closely with psychiatric and medical organizations in the state.

Doctor Urben served for 22 years as a member of the State Medical Society's Division on Nervous and Mental Diseases. Upon his resignation from the Division in 1966, he was accorded a testimonial dinner by the Division and his colleagues.

When Doctor Urben retires in March 1970, Mendota State Hospital will be observing its 110th year. The Secretary of the State Department of Health and Social Services will appoint a new superintendent to carry on the responsibilities of Doctor Urben's position.

A native of Monticello, Doctor Urben received his MD degree from the University of Wisconsin Medical School in 1930. He served his internship at Ancker Hospital, St. Paul, Minn., from 1930 to 1931. He then went to Ohio where he worked in state and private mental hospitals.

Returning to Wisconsin in 1940, Doctor Urben became a staff physician at Mendota State Hospital. In 1943 he left the hospital to become Director of the State Division of Mental Hygiene. He resigned the position in 1948 to return to the hospital as superintendent.

Doctor Urben is a life fellow of the American Psychiatric Association. He is a member of the Wisconsin Psychiatric Association, the Milwaukee Neuro–Psychiatric Society, and his county, state, and American medical associations.

Dr. McRoberts Addresses Green Medical Society

President-elect of the State Medical Society, Dr. J. W. McRoberts* of Sheboygan, addressed thirty-three members of the Green County Medical Society Oct. 28 in St. Clare Hospital at Monroe.

Also addressing the group was Earl R. Thayer, associate secretary of the State Medical Society, of Madison.

Both discussed the relationships of the State Medical Society to the County Medical Society and the relationship of both to the general public.

Dr. S. A. Morton Returns from Lebanon to Speak

Dr. S. A. Morton * formerly professor and chairman, Department of Radiology, Marquette School of Medicine, and presently at the American University, Beirut, Lebanon, will be the speaker at the Annual Dinner meeting on Tuesday, Jan. 20, 1970, of the Milwaukee Academy of Medicine at the University Club of Milwaukee. His subject will be "The Geographic Distribution of Disease."

Dr. C. Norman Shealy*

. . . neurosurgeon at the Gundersen Clinic, La Crosse, recently presented a lecture on "Pain Surgery—Rationale, Techniques and Special Nursing Aspects" in the Lutheran Hospital. It was sponsored by the Adolf Gundersen Medical Foundation in order to familiarize nursing personnel with the latest advances in neuroscience nursing.

Dr. Jack C. Westman*

. . . director of the child psychiatry division at University Hospitals in Madison, recently spoke on the importance of sex education and emotional health of elementary school children with primary emphasis on the psychological and sociological aspects of sex education in the elementary school. Doctor Westman spoke before the Northside School P.T.A. meeting in Monroe. He has been associated with the University of Wisconsin Medical School since 1965.

Dr. F. E. Mohs*

. . . Madison, recently was reelected president of the American College of Chemosurgery at its annual meeting in Atlanta, Ga.

Dr. Mohs

Dr. Hoon

Dr. James R. Hoon*

. . . Sheboygan physician, has been named the 1969 winner of the Man of Action award presented by the Independent Insurance Agents of Wisconsin. It was presented to Doctor Hoon "for his efforts in the use of a gastrocamera, designed to detect diseases of the stomach, and for his contributions to civic growth as president of the Sheboygan Chamber of Commerce."

Dr. Kerim F. Sirin

. . . South Milwaukee, recently was appointed to the medical staff of Trinity Memorial Hospital, Cudahy. He received his medical degree in Turkey and did further medical training at St. Barnabas Hospital, Minneapolis. Doctor Sirin did his specialty training in obstetrics and gynecology at Milwaukee's Columbia and Mt. Sinai hospitals. He has practiced in Turkey and London and was chief of staff at his hospital in Turkey.

Dr. Darrell Lee Witt*

. . . Menomonie, recently became the director of health services at Stout State University. Doctor Witt also will be associated with the Red Cedar Clinic. He was formerly with the Wisconsin State University at River Falls.

Dr. George Nemec, Jr.*

. . . Cambridge, recently was elected chief of staff of the Fort Atkinson Memorial Hospital. Other members of the medical staff are Drs. R. H. Siedenburg,* Jefferson, vice-chief of staff; F. V. Beran,* Fort Atkinson, secretary-treasurer; S. H. Ambrose,* Whitewater, chief of medicine; M. Effenhauser,* Lake Mills, chief of obstetrics; and C. E. Quandt,* Jefferson, chief of surgery.

Dr. A. Y. Gerol*

. . . Racine, recently spoke on drug abuse at a meeting of the Health Careers Club in Racine. The audience consisted mainly of boys and girls in the 9th through 12th grades.

Dr. David J. Strang

. . . Eau Claire, recently became associated with the staff of the Midelfort Clinic. Doctor Strang graduated from the University of Wisconsin Medical School and interned at Minneapolis General Hospital. He completed his residency training in dermatology at the University of Minnesota Hospitals in Minneapolis. He served in the United States Army at the 97th General Hospital, Frankfurt, Germany, before joining the Clinic.

Doctors Rosekrans Honored, Neillsville

Drs. Milton and Sarah Rosekrans,* who have served the Neillsville area for over 40 years, were honored at a dinner Oct. 25 in the Neillsville High School.

The doctors were cited for being extremely active in community affairs. Dr. Milton has served for many years as the city health officer. He also has been interested in the control of water pollution.

Dr. Sarah has been active for many years in the Federated Women's Clubs, and both of the physicians were instrumental in establishing the first hospital in Neillsville.

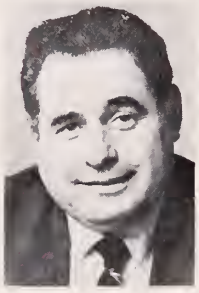
The Doctors Rosekrans received many gifts of appreciation, and greetings were sent from organizations, associations, and from dignitaries throughout the state and country.

Drs. Milton and Sarah Rosekrans

Dr. Josephson Named Clinical Director at Milwaukee Psychiatric Hospital

Dr. Morton Josephson* has been appointed clinical director for Milwaukee Psychiatric Hospital by the board of directors following recommendation of the medical staff, according to an announcement by Dean K. Roe, administrator.

Doctor Josephson, who has served as a member of the fulltime attending staff since 1959, has been director of admissions since 1964. He is also assistant professor in the department of psychiatry at Marquette School of Medicine and is a member of the education committee of the department.



Dr. Josephson

He succeeds Dr. Paul G. Stein,* who will continue as a member of the attending staff.

Doctor Josephson is president-elect of the Milwaukee Chapter of the Wisconsin Psychiatric Association. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology.

Besides his work with patients, Doctor Josephson has been active in the hospital's medical education program. He lectured to senior medical students and because of their work with admissions has been closely associated with their training.

He received his medical education at Columbia College, New York City, and at Chicago Medical School, and completed residencies at the Veterans Administration Hospital, Northport, Long Island, N. Y., and Rochester State Hospital, Rochester, N. Y.

Dr. David Carlson Honored

Dr. David J. Carlson* of Wauwatosa was awarded the E. H. Schaefer Memorial Award by the Milwaukee Division of the American Cancer Society at the division's annual meeting in October.

The award is presented in recognition of exceptional volunteer effort on behalf of the local cancer society.

Rock Officers Elected

During the Oct. 21 meeting of the Rock County Medical Society in Beloit, the following officers for 1970 were elected: president, Dr. L. W. Kleppe,* Beloit; vice-president, Dr. J. S. Pennepacker,* Janesville; and secretary-treasurer, Dr. R. R. Schwaegler,* Beloit.

Doctor Kleppe will succeed Dr. David A. Cohen,* Edgerton.

Fox Valley Area Hospitals Establish Remote Cardiac Monitoring Program

A total of 48 registered nurses from seven hospitals in the Fox Valley area received instruction for remote cardiac monitoring in a seminar at St. Elizabeth Hospital in Appleton in mid-November.

Conducting the seminar were representatives of the Outagamie County Medical Society and the nursing and medical staffs of St. Elizabeth and Appleton Memorial hospitals.

The nurses came from Kaukauna, New London, Clintonville, Chilton, and Waupaca hospitals as well as St. Elizabeth and Appleton Memorial.

The training was part of a new central cardiac center, recently initiated by five of the hospitals, whereby cardiac patients in four outlying hospitals are monitored, via dataphone, by St. Elizabeth Hospital.

The outlying hospitals are Riverview at Waupaca, New London Community, Clintonville, and Chilton.

According to hospital authorities this central cardiac center is the first of its type in the nation to be financed by the hospitals themselves. There are five other such programs across the country but all have been federally funded.

According to Charles Paul, assistant administrator of St. Elizabeth, the program is to admit the coronary patient for treatment at his local hospital. By dataphone, the patient's coronary tracings are sent to St. Elizabeth for monitoring, observation, and interpretation.

MEDICAL STUDENT SCHOLARSHIPS

Applications are now being accepted for the E. V. Allen Memorial Scholarships, open to junior and senior medical students attending medical schools in the United States or Canada. The scholarship provides three months of cardiovascular study at the Mayo Clinic, Rochester, as well as $1,000 award.

Deadline for applications is April 1, 1970. Applicants will be notified by May 1, 1970.

Brochures may be obtained by writing to Minnesota Heart Association, 4701 West 77th Street, Edina, Minnesota 55435.

Waukesha Members Discuss Legislation

Members of the Waukesha County Medical Society met Nov. 5 for regular business and to hear reports on legislative matters.

Jack Brown, regional representative for the State Medical Society of Wisconsin, discussed legislation in which the State Society is interested. He encouraged members to contact their state legislators to make known their views.

Another speaker, Edward Lawler, associate director of field legislative services for Smith, Kline and French and a member of the Mental Health–Mental Retardation Committee of the U.S. Junior Chamber of Commerce, spoke on "What a Pharmaceutical Company is Doing in the Changing Medical Scene."

Dr. John J. Foley,* president, announced the following appointments: Dr. Charles A. Desch* to the Waukesha County Board's Commission on Highway Safety and Dr. Michael R. McCormick* to the fee committee of the State Medical Society.

Doctor Foley asked for volunteers from each religion to form a county committee on religion and medicine. Dr. Joseph Matt* is the county representative to a similar committee of the State Medical Society.

An "Art of Israel" sale was held prior to this meeting, sponsored by Mrs. William Merkow. Twenty percent of the money received from the sale was donated to Marquette medical school.

It was announced that membership directories were being distributed by the Woman's Auxiliary to the Waukesha County Medical Society.

Dr. Charles A. Lipman

. . . a UW Medical School graduate and son of Dr. and Mrs. William H. Lipman* of Kenosha, has been elected to the American Board of Thoracic Surgeons. He is in practice at the La Mesa Surgical Clinic, San Diego, Calif., and is a member of the surgical staff of the University of California Medical School at San Diego.

Dr. Robert E. Callan*

. . . president of the State Medical Society, Milwaukee, was the main speaker at a Ninth Councilor District meeting in Marshfield Oct. 23. Purpose of the meeting was to discuss current medical problems. Dr. Robert W. Mason* of Marshfield, district councilor, was in charge of arrangements.

Dr. Richard F. Daly

. . . of Madison has volunteered to serve for two months aboard the hospital ship SS HOPE in Tunis, Tunisia. His tour started in mid-November. Doctor Daly is a specialist in neurology and is assistant professor of neurology at the University of Wisconsin Medical School.

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Dr. Mark M. Mueller

. . . an internist, and Dr. Jack Heiden,* an orthopedic surgeon, Madison, in early November spoke on current concepts of arthritis care at a free public forum on arthritis held at the McFarland high school. The program was sponsored by the Wisconsin Arthritis Foundation.

Dr. Frank J. Cerny*

. . . Fond du Lac ophthalmologist, and his wife spent the last two weeks of November in Honduras where Doctor Cerny helped develop medical clinics and treated eye diseases. His wife, a nurse, assisted him. Their trip was sponsored by the Christian Medical Society, although their work was volunteered and they paid their own expenses and provided their own medical equipment. Others donated drugs and surgical materials and contributed financially to the mission. In 1961 Doctor and Mrs. Cerny traveled to Africa to work in a mission hospital and made a trip around the world.

Dr. T. L. Goodfriend

. . . Madison, was elected to membership on the Medical Advisory Board of the Council for High Blood Pressure Research at the American Heart Association's 1969 Annual Meeting. Doctor Goodfriend is with the department of medicine and pharmacology at the University of Wisconsin Medical School in Madison.

Dr. H. J. Kief*

. . . representing the Fond du Lac County Medical Society, was recently appointed to a new Fond du Lac County Traffic Safety Council.

Dr. Alex Avestruz

. . . and his wife, Dr. Nerissa Avestruz, recently opened offices in Menomonie. They will continue to have offices in Spring Valley where they have been located for the past two years. The Philipino doctors were house physicians at Unity Hospital, Minneapolis, before starting a clinic at Spring Valley. □

CONTRIBUTIONS—CES FOUNDATION

October 1969

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1969:

Nonrestricted

Guy W. Carlson, MD	Contribution
Dr. and Mrs. L. E. Creasy	Contribution
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E. J. Nordby, MD	Memorial: Marie Carns, MD
Dane County Medical Society	Memorial: Robert E. Burns, MD
State Medical Society	Memorial: James K. Trumbo, MD
State Medical Society	Memorial: Patrick L. Callan, MD
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State Medical Society Employees	Memorial: Arbor Marsh
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Mrs. E. Faulkner	Memorial: Mrs. Emile G. Nadeau

continued on next page

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Jefferson County Nursing Fund

Jefferson County Medical Society	Contribution

Student Loans

State Medical Society Members	Voluntary contributions of 3 MDs
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W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

Danforth Student Loan Fund

Mrs. Quincy H. Danforth	Contribution

History of Nursing in Wisconsin Exhibit

Marquette University College of Nursing	Contribution
La Crosse District Nurses Association	Contribution
Cava Wilson Ross	Contribution

J. H. and W. J. Houghton, MDs Medical Student Award

W. J. Houghton, MD	Contribution

Donations Other Than CESF Projects

State Medical Society Members	Voluntary contributions of 2 MDs

Old Fort Crawford May Be Rebuilt

Old Fort Crawford—a citadel which guarded the Mississippi 140 years ago—may be partially rebuilt as a historic shrine, it was announced by the CES Foundation of the State Medical Society of Wisconsin.

The fortress, which dominated Prairie du Chien—an old fur trade town, was built in 1829 against Indian hostilities, one of a string of military establishments which forged American strength in the old Northwest Territory.

All that remains today is the reconstructed military hospital which was attached to Fort Crawford. The hospital is part of a complex of buildings which form the Museum of Medical Progress and the Stovall Hall of Health in Prairie du Chien.

The site, a national registered landmark and one of two in the United States, is owned and operated by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. It is open from 8–5 daily through October 31.

"A partial reconstruction of old Fort Crawford would serve to bring a rich part of American and Wisconsin history alive again and in a way that could benefit generations to come," said Dr. William D. Stovall,* Madison, president of the Foundation. The medical foundation currently is searching historical records for plans of the Fort.

Dentist Appointed to Board of H&SS

An Eau Claire dentist, Dr. Herbert G. Grewe, earlier this month was appointed to the State Board of Health and Social Services by Governor Knowles.

Dr. Grewe fills the unexpired term of Dr. Frank E. Drew* of Milwaukee who resigned. His term expires May 1, 1971.

Dr. Grewe is immediate past president of the Wisconsin State Dental Society and is chairman of the Eau Claire city–county health department.

SENATOR GAYLORD NELSON (second from right) greeted physicians during the Physicians' Day celebration at Sacred Heart Hospital in Eau Claire October 18. With him are, from left: Dr. Karl Walter of Eau Claire, chief of staff at Sacred Heart; Dr. John Berg of Bethesda, Md., chief of the epidemiology unit of the National Cancer Institute; Senator Nelson of Wisconsin; and Dr. Leland S. McKittrick of Brookline, Mass., professor emeritus of surgery, Harvard Medical School. (Photo courtesy Eau Claire Leader and Daily Telegram)

Eau Claire Physicians' Day Marks Drive for Med Center

The possibility of Eau Claire being a key center for medical services in the state was a major theme at the Sacred Heart Hospital Physicians' Day observance honoring St. Luke, patron saint of physicians, October 18, at Eau Claire.

Approximately 150 doctors and their wives from the tenth councilor district attended the all-day event which began in the morning at Sacred Heart Hospital and continued throughout the day with 12 physicians, all natives of Eau Claire, presenting papers from their area of specialization.

The event was capped in the evening with a banquet at the Davies Center of Wisconsin State University–Eau Claire. Main speaker was Dr. Richard Egdahl, professor and chairman of the department of surgery and associate dean of hospital relations at Boston University School of Medicine. He is a native of Eau Claire, the son of a dentist, Dr. Harry Egdahl.

His talk centered on the relationships between community hospitals and university medical centers. Special guests at the dinner were the deans of the two Wisconsin medical schools, Drs. Gerald A. Kerrigan* (Marquette) and Peter L. Eichman* (UW).

Doctor Egdahl pointed out that because of the expanded facilities and the Allied Health Program being offered at Wisconsin State University, Eau Claire should be considered by medical schools as a possible site for establishing residencies.

"Where doctors put in their residency is more important to where they set up their practice than where they went to medical school," Doctor Egdahl stated.

According to Doctor Egdahl, Wisconsin State University–Eau Claire is destined to be a key center for medical services in the state. The Special Task Force on Medical Education recently reported to Governor Warren Knowles that several cities in the state, including Eau Claire, might develop community health centers with their facilities to form residencies.

The proposed health center at Eau Claire would be established with the cooperation of Luther and Sacred Heart hospitals and Wisconsin State University.

The two Wisconsin medical school deans and some state legislators, also present for the occasion, voiced agreement that a program to keep more physicians in the state and efforts to improve medical services were definitely needed to solve the shortage of doctors in the state and ensure better health for Wisconsin residents.

Physicians presenting papers were:

Dr. Hugh D. Allen, son of Mr. and Mrs. Clark Allen of Eau Claire; fellow in Pediatric Cardiology at the University of Minnesota Hospitals.

Dr. John Berg, born in Eau Claire; Epidemiologic Pathology Unit, National Cancer Institute, Bethesda, Md.

Dr. Richard A. Chilgren, son of Mr. and Mrs. Enar Chilgren of Eau Claire; assistant professor, Department of Pediatrics, associate director of Outpatient Pediatrics, and student education coordinator at University of Minnesota Hospitals.

Dr. Richard Egdahl, born in Eau Claire; professor and chairman of the Department of Surgery and associate dean for Hospital Relations, Boston University School of Medicine.

Dr. Patrick F. Golden, son of Mr. and Mrs. Christopher P. Golden of Eau Claire; neurosurgeon of Sacred Heart Hospital, Eugene, Ore.

Dr. Timothy K. Henke,* native of Eau Claire; member of the Department of Neurology, Gundersen Clinic, La Crosse, Wis.

Dr. Carl M. Manz, son of Dr. and Mrs. Walton R. Manz of Eau Claire; senior surgical resident, University of Minnesota, Veterans Administration Program.

Dr. Leland S. McKittrick, a native of Thorp and schooled in Eau Claire; clinical professor of Surgery, emeritus, Harvard Medical School; honorary surgeon, Massachusetts General Hospital; senior active staff, New England Deaconess; and consultant, Peter Bent Brigham and Veterans Administration Hospital.

Dr. C. F. Midelfort* son of Dr. Christian Midelfort (founder of the Midelfort Clinic); psychiatrist at Gundersen Clinic, La Crosse, Wis.

Dr. Monica Buckley Spaulding, daughter of Dr. and Mrs. R. A.

Buckley of Eau Claire; fellow in Oncology, Department of Internal Medicine, Johns Hopkins University Medical School, Baltimore, Md.

Dr. Sherwood B. Stolp, son of Mr. and Mrs. Sherwood E. Stolp of Eau Claire; instructor in medicine, Marquette School of Medicine; chairman of the Renal Vascular Committee and director of the Kidney Dialysis Unit at St. Luke's Hospital in Milwaukee.

Dr. Peter E. Weinberg, son of Mr. and Mrs. Louis Weinberg of Eau Claire; neuroradiologist at Wesley Memorial Hospital, Chicago, and Northwestern University Medical School.

Moderators for the scientific presentations were Dr. Walton R. Manz,* State Medical Society councilor of the tenth district; Dr. Roland A. Buckley,* and Dr. Samuel L. Henke.*

Dr. Karl E. Walter,* president of Sacred Heart medical staff, and Sister M. Marcellita, OSF, administrator, welcomed their guests for the day's events.

On behalf of the State Medical Society of Wisconsin, Dr. Robert E. Callan* of Milwaukee, president, sent the following telegram to Councilor Manz and Sacred Heart Hospital of Eau Claire: "Congratulations to the Eau Claire community for its fine program in tribute to the medical profession. The State Medical Society is proud of its outstanding members in Eau Claire, proud of their excellent professional skills, proud of their service to the people of your area, proud of their role in the life of the community. Please convey our best wishes to Eau Claire and its physicians."

Halverson Lecture Given

Dr. James L. Poppen, neurosurgeon of the Lahey Clinic, Boston, Mass., was the Halverson Visiting Professor of Neurological Surgery at the University of Wisconsin Medical Center from Nov. 13 to Nov. 15. On Nov. 14 he delivered a lecture entitled "Surgical Management of Intracranial Aneurysms and Arteriovenous Malformations." The Visiting Professorship is provided by Harold F. Halverson and family of Beloit.

HONORING ST. LUKE at festivities at Sacred Heart Hospital in Eau Claire October 18 were these dignitaries, from left: Assemblyman Louis V. Mato of Eau Claire; Dr. Richard H. Egdahl, associate dean of hospital relations of the Boston University Medical School, Mass.; Dr. Gerald A. Kerrigan, dean of Marquette School of Medicine, Milwaukee; and Dr. Peter L. Eichman, dean of the University of Wisconsin Medical School, Madison. (Photo courtesy Eau Claire Leader and Daily Telegram)

Dr. Kubiak: Physician to Alcoholics

The recently named director of the alcoholism treatment unit at Winnebago State Hospital is Dr. Mary Kubiak,* wife of a pharmacist and mother of five children.

She was featured in a full-page story in the Nov. 16 issue of the GREEN BAY PRESS–GAZETTE.

Doctor Kubiak, who joined the hospital staff in 1955, succeeded Dr. George Lysloff who is now in charge of the newly established research project at the hospital.

The new Gordon Hall treatment center was built just over a year ago on the hospital grounds where the Kubiak family also lives.

Doctor Kubiak is enthusiastic about the new facilities and its program. She wishes there were a halfway house, and someday there just might be one because she has discussed the possibility with Oshkosh officials and businessmen who also are interested.

She met her husband, Donald, while both were attending the University of Wisconsin. He is chief pharmacist at Mercy Hospital, Oshkosh. She feels that his understanding of her work has helped them both get the most out of their professional and private lives. She prefers her position to private practice. "It keeps me on my medical toes and allows me time to enjoy my family," she remarked.

Dr. Mary Kubiak

Doctor Kubiak is a crusader for women in medicine. "Possibilities are unlimited," she points out. (Photo courtesy GREEN BAY PRESS–GAZETTE)

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF NOVEMBER 1969

4 Committee on Health Careers, Wisconsin Hospital Association and State Medical Society Auxiliaries
4 Madison General Hospital Surgical Staff
4 Madison Anesthesiology Society
4 Madison Urological Society
4 Dane County Medical Society Board of Trustees
6 Executive Committee, SMS Commission on Medical Care Plans
6 Madison Academy of Internal Medicine
7 Symposium on Myocardial Infarction, Its Prevention and Treatment for Registered Nurses
7 SMS Commission on Scientific Medicine
13 SMS Committee on Government Programs
13 Medwives
17 Department of Surgery, University Hospitals
18 Planning Committee, Wisconsin Regional Medical Program
20 Nursing Committee, Wisconsin Regional Medical Program
20 Wisconsin Regional Medical Program Staff
20 SMS Division on Aging
22 SMS Council
23 SMS Division on Rehabilitation
24 Insurance Advisory Committee, Dane County Medical Society

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Dr. Epstein Links Preservative to Rheumatism

A University of Wisconsin physician, using himself as a guinea pig, has linked a common food preservative and a widely-used flavoring chemical to recurring rheumatism, according to a report recently published in *The Annals of Allergy*.

Dr. Stephan Epstein,* clinical professor of dermatology at the UW Medical Center in Madison, has established that sodium nitrate, a color preservative for meats and vegetables, and peppermint oil, are both primary villains in his attacks of palindromic rheumatism.

For the past four years, the 69-year-old professor had experienced inexplicable attacks of moderate to severe arthritic pain in his joints. Diagnosing his ailment as a type of rheumatism brought on by some sort of allergy, he began his search for the culprit by testing the various suspected foods on himself.

He stressed that his report should not alarm people because "the nitrates have been used in foods for decades, and it has not been shown that the small amounts permitted in foods are harmful to people. My case is probably just a rare instance of allergy."

"Though mine is only a single case, it is the first authenticated report in which hypersensitivity to sodium nitrate has been definitely established, and also as the main cause of a case of palindromic rheumatism," he added.

His report concluded by saying: "These observations also indicate that apparent 'allergy' to numerous foods actually may be caused by a single ingredient common to them all. A common food additive, unsuspected for decades, may be an allergen."

Doctor Epstein joined the University teaching faculty in 1965 when he retired from the Marshfield Clinic where he had practiced for 29 years.

Doctors Attend National Fracture Meeting, Ohio

Three Wisconsin physicians were among speakers at the 30th annual meeting of the American Fracture Association held in November at Columbus, Ohio.

Dr. Paul K. Odland,* Janesville; Dr. George L. Thomas,* Delavan; and Dr. Karl H. Mueller, Milwaukee,* presented a symposium on the "Use of Image Intensifier Units in Orthopaedic Surgery with Television."

Periodontal Disease Talk

The Winnebago County medical and dental societies met jointly Nov. 4 at The Pioneer in Oshkosh. The featured speaker was Doctor LaBelle of the University of Minnesota who discussed "Periodontal Disease."

La Crosse Society Meets

A general discussion on drug abuse by the younger generation and various educational proposals were major topics at the Oct. 20 meeting of the La Crosse County Medical Society. □

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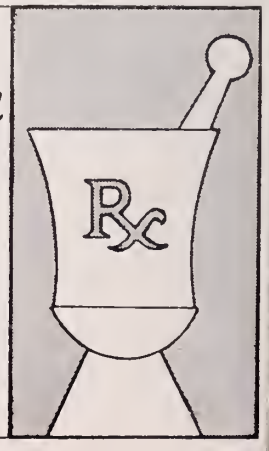

OBITUARIES

Dr. James K. Trumbo, 72, well known Wausau ophthalmologist, died June 21, 1969, in Wausau.

Born on May 5, 1897, in Blue Rapids, Kansas, Doctor Trumbo graduated from the Northwestern University Medical School in 1923 and served his internship at Children's Memorial Hospital and Cook County Hospital, Chicago, Ill. He had practiced in the Wausau area from 1929 until his retirement in 1962.

Doctor Trumbo took his residency at the Illinois State Charitable Eye and Ear Infirmary in Chicago and also studied at the University of Vienna, Austria. He also served as chief of the Department of Ophthalmology and Otolaryngology at St. Mary's Hospital, Wausau, for a number of years.

He was a member of the International College of Surgeons and the American Academy of Ophthalmology and Otolaryngology.

He was a member of the Marathon County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Jane; and two sons, John K., Milwaukee, and James, Silver Spring, Md.; and a daughter, Mrs. Andrew Hunter of New Canaan, Conn.

Dr. Robert E. Burns, 74, prominent Madison orthopedic surgeon, died Sept. 8, 1969, after a long illness.

Born May 6, 1895, in Wisconsin Rapids, Doctor Burns graduated from the University of Pennsylvania Medical School in 1919. He took his internship at St. Mary's Hospital, Madison, and received his specialty training at the Hospital for the Ruptured and Crippled, New York, and at the Mayo Clinic. He is a member of the alumni associations of both institutions.

Doctor Burns served at the University of Wisconsin Medical School as instructor, assistant and associate professor, 1923–1930, and was professor of Orthopedic Surgery and chief of the Orthopedic Service from 1930 until his retirement in 1962, because of ill health. He was a member of the American College of Surgeons, American Academy of Orthopedic Surgeons, American Orthopedic Association, International Society of Orthopedic Surgery and Traumatology, and the American Fracture Association. He was a past president of the Clinical Orthopedic Society and the Wisconsin Orthopedic Association.

In 1968, he was honored by the Wisconsin Medical Alumni Association with the Emeritus Professor award of the year and in 1969, the State Medical Society of Wisconsin honored him in the "50-year Club."

He was also a member of the Dane County Medical Society and the American Medical Association.

Surviving are his widow, Charlotte; a son, Thomas C., and two daughters, Dr. Charlotte, Iowa City, Ia., and Mrs. Richard (Mary Ellen) Gibbs, Billings, Mont.

Dr. Patrick L. Callan, 81, Milwaukee, died Sept. 9, 1969, in Milwaukee.

Born on Mar. 19, 1888, in Dundalk, Ireland, Doctor Callan graduated from the St. Louis University Medical School in 1921. His internship was served at St. Joseph's Hospital, Kansas City, Mo. Doctor Callan served in World War I in the Mobile Hospital Unit. He had practiced in the Milwaukee area since 1922.

At the time of his death, Doctor Callan was a member of the American, Wisconsin, and Milwaukee Academies of General Practice. He also was an honorary staff member of St. Luke's and St. Francis hospitals in Milwaukee.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association.

Surviving is his widow, Kate. He was the uncle of Dr. Robert E. Callan, Milwaukee, current president of the State Medical Society of Wisconsin.

Dr. A. C. Edwards, 80, Baraboo, died Sept. 10, 1969, in Baraboo.

Born July 30, 1889, in Beetown, Wisconsin, Doctor Edwards graduated from the University of Illinois Medical School in 1913 and interned at St. Francis Hospital, La Crosse.

He was a past president of the Sauk County Medical Society, member of the State Medical Society of Wisconsin, and American Medical Association.

Surviving are two daughters, Mrs. Schuyler French, Milwaukee, and Margaret Mary, Milwaukee; and one son, James, McFarland.

Dr. William A. Sneeberger, 84, Ephraim physician for 45 years, died Oct. 13, 1969, in Ephraim.

Born in Racine on Sept. 25, 1885, Doctor Sneeberger graduated from Rush Medical College, Chicago, in 1917 and practiced in Orfordville and Racine before coming to Ephraim.

In 1965, Doctor Sneeberger was elected Ephraim's first "Fry Bal Fest Chieftain" for his contributions to the life and betterment of Ephraim.

Surviving are his widow, Dorothy; one son, Robert, Elgin, Ill.; and a daughter, Mrs. Emery (Mary Lou) Eatough, Manitowoc.

Dr. Urban E. Gebhard, 65, a practicing physician in Milwaukee for 38 years, died Oct. 14, 1969, in Milwaukee.

Born Apr. 5, 1904, in Milwaukee, he graduated from South Division high school where he was a member of its championship football teams in 1918, 1920, and 1921.

He did undergraduate work at the University of Notre Dame where he was on its track team in 1923 and 1924. He received his MD degree in 1930 from Northwestern University Medical School.

In 1930–1931, Doctor Gebhard interned at Milwaukee County General Hospital. He was on the staffs of St. Luke's, St. Francis, and Sacred Heart Rehabilitation hospitals.

Doctor Gebhard, a surgeon, was medical director for Rex Chainbelt, Inc., for more than 25 years until his retirement in 1969. He also was medical director for the Milprint division of Phillip Morris, Inc., at the time of his death.

He was a member of the American Society of Abdominal Surgeons, a fellow of the American Association of Industrial Physicians and Surgeons, and the International College of Surgeons. He was a past president of the Central States Society of Industrial Medicine and Surgery.

Doctor Gebhard was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Elva; and a daughter, Mrs. William B. Gardner, Jr., Austin, Tex.

Dr. William E. Curtis, 69, Waunakee, died Oct. 18, 1969, in Waukesha.

Born Sept. 4, 1900, in Ottawa, Ill., Doctor Curtis graduated from Marquette University School of Medicine in 1927 and served his internship at Milwaukee Maternity and General Hospital.

Surviving are his son, Dr. William C., Elm Grove; and a daughter, Mrs. Josephine H. Dugan, New Berlin.

Dr. Marcus M. Guzzetta, 66, Milwaukee physician, died Oct. 25, 1969, in Milwaukee.

Born in Italy on Sept. 14, 1903, Doctor Guzzetta graduated from the Northwestern University School of Medicine in 1928 and interned at St. Mary's Hospital in Milwaukee. He served in the United States Army Medical Corps in World War II, where he was commissioned a major.

Doctor Guzzetta was part of a family tradition of medical practitioners and other professionals that dates back into the history of Sicily. He was preceded in death by his father, Dr. Philip Guzzetta, and two other physician brothers, Drs. Denis and Vincent J. Guzzetta. The Guzzetta family had operated a clinic in Milwaukee from the 1920s to mid-1960s. Until his death a brother-in-law, Dr. Frederick Kretlow, also was associated with the family clinic.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, and American Academy of General Practice.

Surviving are his widow, Myrtle; two daughters, Jean Wheelihan, Lake Worth, Fla., and Marcia Curtis of West Lebanon, New Hampshire; and a son, Philip M., of Glenview, Ill.

Also surviving are a sister and two brothers, one of whom is Dr. Philip C. Guzzetta who resides in Elm Grove.

Dr. Marie L. Carns, 77, died Sept. 29, 1969, in Madison.

Born on Oct. 26, 1892, Doctor Carns graduated from the University of Wisconsin Medical School in 1927 and served her internship at Worcester Memorial Hospital, Worcester, Mass. She was an associate professor of medicine at the University of Wisconsin and was named director of the department of physical education for women in 1946. She retired several years ago.

Dr. Daniel F. Nauth, 90, Kiel physician since 1907, died Nov. 11, 1969, in Kiel.

Born Mar. 30, 1879, at Rhine Center, Sheboygan County, he graduated from Northwestern Medical College, Evanston, Ill. in 1906 and interned at Rockford City Hospital. Doctor Nauth served on the medical staffs of the St. Nicholas and Memorial hospitals in Sheboygan, Plymouth Hospital and the Calumet Memorial Hospital, Chilton.

In 1914, he became the first president of the Kiel Citizens State Bank, a position he held for 50 years, and had been chairman of the board since 1968.

The Kiel Chamber of Commerce honored Doctor Nauth with a testimonial dinner in 1958 for his service to the community, and the Kiel Kiwanis Club selected him "Man of the Year" in 1964.

He was a member of the Sheboygan County Medical Society, "50 year" club member of the State Medical Society of Wisconsin, and a member of the American Medical Association.

Surviving is a daughter, Mrs. Donald (Lois) Wiedenfeller, Whitefish Bay. □

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

MODERN TREATMENT

Vol. 6, No. 3. *Treatment of Thyroid Disease,* guest editor, James A. Pittman, Jr., MD and *Treatment of Vertigo,* Special Article by Myron W. Frederic, MD, Wallace Rubin, MD and Robert Wolfson, MD. Hoeber Medical Division, Harper & Row, Publishers, 49 East 33 St., New York, N.Y. 10016. Published bimonthly. 1,500 pages annually. Subscription: $16 per yr.

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY

By George A. Ulett, MD, PhD, and D. Wells Goodrich, MD. The C. V. Mosby Company, Saint Louis, Mo. 1969. 340 pages. Price: $9.50.

URINARY TRACT INFECTION IN CHILDHOOD AND ITS RELEVANCE TO DISEASE IN ADULT LIFE

By Victoria Smallpeice, MA, MD, FRCP. The C. V. Mosby Company, Saint Louis, Mo. 1969. 171 pages. Price: $9.50

MANUAL ON ARTIFICIAL ORGANS, Vol. I, The Artificial Kidney —A guide to understanding for the physician and patient

By Yuhihiko Nose, MD, PhD. The C. V. Mosby Company, Saint Louis, Mo. 1969. 343 pages. Price: $27.75

MODERN TREATMENT

Vol. 6, No. 4. *Psychiatry in Medical Practice,* guest editors, Ephraim T. Lisansky, MD and Bernard R. Shochet, MD. Hoeber Medical Division, Harper & Row, Publishers, 49 East 33 St., New York, N.Y. 10016. Published bimonthly. 1,500 pages annually. Subscription: $16 per yr.

SURGEON'S CHOICE

By Frank G. Slaughter, MD. Doubleday & Company, Inc., 227 Park Avenue, New York, N.Y. 10017. 1969. 345 pages. Price: $5.95

WORKING WITH OLDER PEOPLE, Vol. I: The Practitioner and the Elderly

United States Department of Health, Education, and Welfare. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., 20402. 54 pages. Price: 65¢

POTIONS, REMEDIES, AND OLD WIVES' TALES

By W. W. Bauer, MD. Doubleday & Company, Inc., 277 Park Avenue, New York, N.Y. 10017. 1969. 319 pages. Price: $5.95

CURRENT PRACTICE IN ORTHOPAEDIC SURGERY

Vol. 4, by John P. Adams, BS, MD, FACS, Editor. The C. V. Mosby Co., Saint Louis, Mo. 1969. 286 pages. Price: $22.50

MENTAL HEALTH AND THE COMMUNITY: Problems, Programs, and Strategies

Edited by Milton F. Shore, PhD and Fortune V. Mannino, PhD. Behavioral Publications, Inc., 2852 Broadway, New York, N.Y. 10025. 209 pages

continued on page 74

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF NOVEMBER 12, 1969

NEW MEMBERS

Bogart, Keith C., 1836 South Ave., La Crosse 54601
Brummitt, Charles D., 785 Thackeray Trail, Oconomowoc 53066
Brusky, John D., 1203 South Military Ave., Green Bay 54304
Caplan, Robert H., 1836 South Ave., La Crosse 54601
Cross, W. Michael, 900 South Webster Ave., Green Bay 54301
Eder, Richard L., 507 E. First Street, Hayward 54843
Esswein, James L., 220 Douglas St., Chetek 54728
Fiester, Richard F., 3003 South 28th St., Milwaukee 53215
Garvida, Cesar A., Manawa 54949
Hartigan, J. Michael, 1836 South Ave., La Crosse 54601
Heath, Hunter, III, 401 Eugenia Ave., Madison 53705
Hededus, Alexander A., 97 South Huron Dr., Janesville 53545
Katz, Mayer, 1146 Grant Ave., Beloit 53511
Kiselow, Mark C., 1212 West Wisconsin Ave., Milwaukee 53233
Kovich, Eleanore, 2413 Calypso Rd., Apt. 6, Madison 53704
Lelonek, Robert D., 1111 Delafield, Waukesha 53186
Levenson, Ina, 2500 West Lincoln Ave., Milwaukee 53215
McClelland, G. Bruce, 1553 North 116th St., Wauwatosa 53226
Murphy, Raymond J., 1751 Deckner Ave., Green Bay 54302
Pier, William J., Jr., 2200 West Kilbourn, Milwaukee 53233
Reed, Alan E., Jr., 4302 North 91st St., Milwaukee 53222
Scanlon, Gerard T., 8700 West Wisconsin Ave., Milwaukee 53226
Solochek, Sheldon M., 4031 North 91st St., Milwaukee 53222
Stilp, Lyall C., II, U.S. Army Hospital, Fort Campbell, Ky. 42223
Tischer, E. Paul, 1313 West Seminary St., Richland Center 53581
Underberg, John T., 725 American Ave., Waukesha 53186
Wessel, Gilbert R., 59 Racine St., Menasha 54952
Wineinger, David M., 923 Eliza St., Green Bay 54301

REINSTATED

Ziegler, Clement T., 5856 North Port Washington Rd., Milwaukee 53217

CHANGES OF ADDRESS

Alstadt, John F., 6080 South 108th St., Hales Corners 53130
Apell, Melvin G., 645 Doctors Court, Oshkosh 54901
Babbitz, S. G., Milwaukee, to Box 608, Hallandale, Fla. 33009
Beno, Thos. J., 1751 Deckner Ave., Green Bay 54302
Boersma, John J., 519 South Monroe Ave., Green Bay 54301
Chapman, M. J., 411 Carrington, Waupun 53963
Chrzan, Donald J., 4404 West Oklahoma Ave., Milwaukee 53219
Clark, Eugene V., Jr., 130 E. Walnut St., Green Bay 54301
Creasy, Leurner E., 3751 S. School Ave., Apt. 12, Sarasota, Fla. 33579
Czajka, John J., 6080 South 108th St., Hales Corners 53130
Danaher, Harry H., 205 East Walnut St., Green Bay 54301
DeCook, R. D., 612 E. Longview Ave., Appleton 54911
Enders, Lawrence J., P. O. Box 35373, Brooks AFB, Tex. 78235
Erickson, John R., 1410 Water St., Stevens Point 54481
Fernandez, Pascual B., Milwaukee, to University of Minnesota, Minneapolis, Minn. 55455
Fisk, Norman M., Milwaukee, to 13355 La Cresta, Los Altos Hills, Calif. 94022
Foerster, Frederick E., 929 N. Astor St., Apt. 1101, Milwaukee 53202
Freedman, Albert L., 130 E. Walnut St., Green Bay 54301
Gemmill, Worthy D., 97th General Hospital, APO, New York, N. Y. 09757
Geretti, Roland J., Milwaukee, to 2233 Oak Park Dr., Tucson, Ariz. 85710
Glise, Roy C., Jr., 1313 West Seminary St., Richland Center 53581
Graber, L. D., 650 Doctors Ct., Oshkosh 54901
Gramowski, Walter A., 1224 North Green Ave., Stevens Point 54481
Graves, Richard H., 1552 University Ave., Madison 53706
Guenther, V. G., 650 Doctors Ct., Oshkosh 54901
Hammes, David A., Green Bay, to 3321 N. Maryland Ave., Milwaukee 53211
Hara, Kinge, 4404 W. Oklahoma Ave., Milwaukee 53219
Hartzler, Paul L., Grantsburg, to Cambridge Clinic, Cambridge 55008
Hein, W. E., 1915 Roosevelt Rd., Monroe 53566
Hering, George V., 128 Main St., Denmark 54208
Hirschler, Charles W., Madison, to 202 N. Jefferson, Verona 53593
Housner, Richard E., 1313 W. Seminary St., Richland Center 53581
Isom, R. G., 650 Doctors Ct., Oshkosh 54901
Kane, Alex M., 2588 N. Frederick Ave., Milwaukee 53211
Koehler, A. G., P. O. Box 945, Oshkosh 54901
Kohn, Albert M., 900 Illinois Ave., Stevens Point 54481
Leonard, T. A., 5717 Century Ave., Middleton 53562
Limjoco, Uriel R., Madison, to N85 W15634 Menomonee River Parkway, Menomonee Falls 53051
MacMullin, Wallace, II, 1751 Deckner Ave., Green Bay 54302
McCanna, P. R., 612 East Longview Ave., Appleton 54911
Majeski, Harry E., 206 Main St., Luxemburg 54217
Merline, Gerald B., 502 George St., DePere 54115
Miller, Stanley R., 950 College Ave., Stevens Point 54481
Montgomery, Terryl B., 606 W. Wisconsin Ave., Milwaukee 53203
Monsted, John W., 122 North Water St., New London 54961
Newberg, Lewis B., Milwaukee, to 5146 Downwest Ride, Columbia, Md. 21043
O'Loughlin, Peter, 1134 Kavanaugh Place, Milwaukee 53213
Olsen, E. H., Jr., Madison, to 12580 Green Meadow Place, Elm Grove 53122
Olson, Lyle L., 517 Park Pl., Darlington 53530
Palmer, Karl A., Menomonie, to University of Pennsylvania, Philadelphia, Pa. 19104
Parke, George, Jr., 1313 West Seminary St., Richland Center 53581
Pitlyk, Paul J., APO, San Francisco, Calif., to 1750 El Camino, Burlingame, Calif. 94010
Plotkin, Martin, Madison, to USAF Hospital, All Hospital Mail Room Box #10219, Maxwell AFB, Ala. 36112
Ruf, David F., 517 Park Pl., Darlington 53530
Russell, John H., 612 E. Longview Ave., Appleton 54911
Schierl, Anne G., 900 Illinois Ave., Stevens Point 54481
Schmallenberg, H. C., 202 North Water St., New London 54961
Schmidt, Robert A., Milwaukee, to 1205 Fairhaven Blvd., Elm Grove 53122
Sciarrone, Francesco, 900 Illinois Ave., Stevens Point 54481

Shippy, Vincent J., 123 West Pulaski, Pulaski 54162
Sladky, James A., Milwaukee, to Route 1, Box 792, Waterford 53185
Sowka, Paul N., 1525 Main St., Stevens Point 54481
Spear, Jack I., 1313 West Seminary St., Richland Center 53581
Stein, Leonard I., 2725 Marshall Ct., Madison 53705
Tydrich, James J., 1313 West Seminary St., Richland Center 53581
Urben, W. J., 1219 Wellesley Rd., Madison 53705
Vande Loo, Francis B., 229 Main St., Wrightstown 54180
Vangor, Donald W., Wisconsin Dells, to 703–14th St., Baraboo 53913
Waldkirch, Bernard P., 502 George St., DePere 54115
Weber, Joseph W., 525 High St., New London 54961
Wilson, Stuart D., Lake Bluff, Ill., to 13330 Oakhurst Ave., Elm Grove 53122
Yasatan, Nasip H., 505 Mulberry Lane, Racine 53402

REMOVED FROM MEMBERSHIP

Bauman, Billy J., Dane County
Bjornson, Jan, Dane County
Connolly, John E., Brown County, removed per county secretary
Dehne, Kurt G., Milwaukee County, resigned
Doubrava, Sterling M., Waukesha County, transferred to Arizona
Frechette, Paul F., Dane County
Hoegemeier, Harry W., Brown County, resigned
Jackson, Robert D., Dane County
Jaques, Darrell A., Brown County, removed per county secretary
Kirsch, John M., Milwaukee County, transferred to Illinois
Lawton, L. M., Marathon County
Marx, Arnold J., Dane County
Nolta, Robert T., Rock County, transferred to Michigan
Phillips, Thomas A., Clark County, removed per county secretary
Prouty, Lawrence, Dane County
Reynoso, Gustavo, Milwaukee County, transferred to New York
Schmidt, Erich M., Green Lake–Waushara County, removed per county secretary
Siedband, Gerald N., Milwaukee County, transferred to Nebraska
Slocumb, Charles O., Kenosha County, transferred to California
Tweeten, John B., Eau Claire–Dunn–Pepin County, transferred to Colorado
Vermund, Halvor, Dane County
VonJarchow, Bruno L., Racine County

DEATHS

Edwards, Alba C., Sauk County, Sept. 10, 1969
Carns, Marie L., nonmember, Sept. 29, 1969
Sneeburger, William A., nonmember, Oct. 13, 1969
Gebhard, Urban E., Milwaukee County, Oct. 14, 1969
Curtis, William E., nonmember, Oct. 18, 1969
Guzzetta, Marcus M., Milwaukee County, Oct. 25, 1969 □

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BOOKSHELF *continued from page 64*

COORDINATE INDEX REFERENCE GUIDE TO COMMUNITY MENTAL HEALTH
By Stuart E. Golann, PhD. Behavioral Publications, Inc., 2852 Broadway, New York, N.Y. 10025. 1969

PSYCHOLOGICAL AND SOCIAL ASPECTS OF HUMAN TISSUE TRANSPLANTATION: An Annotated Bibliography, Supplement No. 1
By Jacquelyn H. Hall, MS and David D. Swenson, MD. National Clearinghouse for Mental Health Information, National Institute of Mental Health, 5454 Wisconsin Ave., Chevy Chase, Md. 20015 U. S. Department of Health, Education, and Welfare. 1969. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 40 pages. Price: 35¢

ESSENTIALS OF GYNECOLOGY
By E. Stewart Taylor, MD. Fourth Edition. Lea & Febiger, 600 S. Washington Square, Philadelphia, Pa. 19106. 588 pages. Price: $17.50

MENTAL HEALTH CONSIDERATIONS IN PUBLIC HEALTH
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—Statement authorized by House of Delegates, Oct. 22, 1966

The "Blue Book"

SINCE 1924 the *Wisconsin Medical Journal* has published each January a "Blue Book" edition containing a variety of articles relating to medico-legal matters of direct concern to the physician in his relationship to patients, hospitals, governmental agencies, and others on the "health team." It is unique among medical journals of the United States.

An evaluation of the "Blue Book" through a questionnaire in the 1968 edition has been overwhelmingly favorable toward its continuance. While the number of replies was small, the percentage favoring continuance and praising its value exceeded 95 percent. The comments included a number of constructive criticisms and suggestions which the editors appreciated. Some of these have been incorporated in this issue.

New articles appearing in this issue are:

- Must a Wisconsin Physician Report?
- Attorney General's Opinion: Nontherapeutic Sterilization
- Notes on Ethics: Contingent Fees and Medical Expenses
- The Quest for Information
- Prescribing Drugs: What the Federal Law Requires

Articles reprinted have been updated where applicable. Your attention is called to the editor's notes at the end of the articles, "The Professional Corporation in 1968," and "Physician and Hospital Records Retention and Inspection."

There also is a new boxed item accompanying the article, "What Every Doctor Should Know About Workmen's Compensation." Other minor changes have been made in the articles, "Problems of a Physician's Widow," "Your Deadlines and Other 'Musts'," and "Narcotics."

Section 3, Chapter XI, of the Constitution and Bylaws was amended at the May 1968 House of Delegates session. The amendment appears in the reprinting of the Constitution and Bylaws in this issue.

Of further note is the current directory of the Wisconsin Legislature as compiled by the Wisconsin Taxpayers Alliance.

The "Blue Book" issue is an outstanding medical legal service to members of the Society. A permanent file of these issues for future reference is recommended.

SAVE YOUR "BLUE BOOK" ISSUE FOR FUTURE REFERENCE

OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL—AMA

The Principles of Medical Ethics of the American Medical Association were condensed in 1957 to a preamble and ten sections. This preamble appears in this issue at page 53. Opinions of the Judicial Council interpreting the Principles are set forth in a booklet entitled, "Judicial Council Opinions and Reports: 1966." The booklet includes the jurisdiction and rules of the Judicial Council. Actions of the AMA House of Delegates relating to the Principles also are reproduced. This guide to good conduct is available upon request to the AMA, 535 North Dearborn Street, Chicago, Ill. 60610.

MUST A
Wisconsin Physician Report?

1. Deaths?

The Wisconsin Statutes require that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.

b. All homicides.

c. All suicides.

d. All deaths following an abortion.

e. All deaths due to poisoning, whether homicidal, suicidal or accidental.

f. All deaths following accidents, whether the injury is or is not the primary cause of death.

g. When there was no physician in attendance within 30 days preceding death.

h. When a physician refuses to sign the death certificate.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Industrial diseases?

Yes, to the Division of Health, Department of Health and Social Services for diseases as required by statute.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful.

Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. Communicable diseases?

Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. Venereal diseases?

Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702. Patients delinquent in reporting for treatment must also be reported to the Division.

13. Cancer?

No.

14. Tuberculosis?

Yes, to your local Board of Health.

15. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

16. Epileptics?

No. A special duty to certify by a physician in certain cases is discussed on page 43 of this issue.

17. Drug addiction?

No.

18. Abused children?

Yes. See article page 31 of this issue.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

ATTORNEY GENERAL'S OPINION

Nontherapeutic Sterilization

IN LATE NOVEMBER the Attorney General of Wisconsin issued a formal opinion on the question of whether a voluntary nontherapeutic sterilization operation performed by a physician in Wisconsin is legal. The opinion had been sought by the State Medical Society of Wisconsin, the Wisconsin Urological Society, the Medical Examining Board, and others for more than two years. The State Medical Society's House of Delegates in May 1968 adopted a resolution urging the Attorney General's opinion on this subject. The opinion, which was dated Nov. 25, 1968, follows:

Thomas W. Tormey, Jr., M.D.
Secretary
Medical Examining Board
Department of Regulation and Licensing
State of Wisconsin
110 North Henry Street
Madison, Wisconsin 53703

Dear Dr. Tormey:

You have asked whether a voluntary non-therapeutic sterilization operation performed by a doctor in Wisconsin is legal.

I shall limit this opinion to the common sterilization operation known as salpingectomy for the female patient and vasectomy for the male patient. As distinguished from more serious sterilization operations such as castration, the only physiological change in the patient from these operations is removal of the ability to procreate.

I shall further limit my discussion of the question as it relates to the criminal law of the State of Wisconsin and refrain from discussing any aspects of civil law.

There is no applicable statute or common law principle in Wisconsin which would make a physician performing a non-therapeutic sterilization operation requested by the patient guilty of a crime.

I have searched extensively for a case holding that such an operation constituted a crime at common law and have found none.

However, earlier legal writers have suggested that a court might construe the battery or the mayhem statute to include such an operation.[1]

Wisconsin's mayhem statute, section 940.21, Wis. Stats., provides:

> "Whoever with intent to disable or disfigure another, cuts or mutilates the tongue, eye, ear, nose, lip, limb or other bodily member of another, may be fined not more than $5,000 or imprisoned not more than 15 years or both."

It is readily apparent that this statute may not be literally construed. For instance, it makes no exception for the surgeon performing life-saving but very disabling operations such as the severing of a gangrenous hand or the removal of a cancerous eye, for the dentist pulling an infected or unwanted tooth, for the plastic surgeon performing cosmetic surgery, or for a host of other surgical operations which disable or disfigure the patient. Yet no one could seriously contend that the legislature meant to include such operations performed by surgeons or dentists within the literal language of this statute.

In considering whether the Wisconsin mayhem statute applies to non-therapeutic sterilization operations requested by the patient, it is helpful briefly to discuss the history of the law of mayhem.

In early English common-law mayhem was the procurement of a physical disablement with the intent to render oneself unfit to fight for the King, such as the severing of one's bow fingers. Under such circumstances, both the patient and the surgeon or other contributing party were guilty of committing a crime against the King, that of mayhem.

In the famous Wright's case, Coke, §194 (127b), the defendant persuaded another to sever his hand so as to pass more convincingly as a beggar rather than to be a productive worker in the King's realm. This, under the early common law, was indictable mayhem.

The common law of mayhem was expanded to include any severe malicious disfigurement or mutilation of a bodily member by one person upon another.

Through this short discussion of the early history of the law of mayhem, two legal concepts emerge:

(1) Under the common law development of mayhem, consent did not excuse the actual performer of the operation. As stated in *Bishop's Criminal Law*, (9th Ed.), Section 259 (2):

> "It being the gist of the crime in mayhem that the injured person is rendered less able in fighting, one may not innocently maim himself; therefore if at his request another maims him, both are guilty."

(2) The act was done maliciously,—that is, done with wicked or mischievous motives or intentions, the malicious aspect being to do harm or injury either to the maimed individual or to the state.

It is important to keep in mind that mayhem was never an indictable crime unless it has been perpetrated with malice as just defined. 36 Am. Jur., Mayhem §3. And it should be noted also that throughout the history of the law of mayhem, legal

[1] Herzog, *Medical Jurisprudence*, sec. 1020 et seq.

operations performed by physicians were not considered to be mayhem. This was not because the patient consented, but because, lacking the element of malice, the "maiming" resulting from a legal operation never approached the threshold of legal mayhem.

Until 1955, Wisconsin's mayhem statute required an element of *malicious* intent.[2] This conformed to the common law and it is obvious that physicians performing legal operations would not be violating the mayhem statute prior to 1955 as long as the operation was not performed with malicious intent.

In 1955, the legislature, in adopting new revised criminal code (L. 1955, Ch. 696), passed the current version of the mayhem statute which omitted the element of malice. However, this legislature also adopted a new section, sec. 939.10:

> "Common-law crimes are abolished. The common-law rules of criminal law not in conflict with the criminal code are preserved."

Sec. 940.21, Stats. (1965), Wisconsin's current mayhem law, must be construed in light of this last-cited section. It follows that indictable mayhem in Wisconsin still requires the element of malice. Any other construction would, in my opinion, render sec. 940.21, Wis. Stats., invalid on its face since it makes no exception for the physician performing a legal, although disabling or disfiguring, operation. If a statute is capable of two constructions, one of which renders it invalid and another which renders it valid, the later construction will prevail.[3]

Since we are considering an essentially nontherapeutic operation, we must consider whether the operation is "malicious" within the scope of that term as previously discussed. In short, we must ask: Is the end result—the incapacitation of procreation—a malicious act against either the person receiving the operation or against the state?

It is my opinion that, insofar as individual maliciousness is concerned, the "intent to disable or disfigure another" is lacking in a voluntary sterilization operation. Not only is the element of malice lacking, but it is highly questionable whether the disabling element is present when the "disabling" is the very end result rationally desired by the patient.

It is also my opinion that under these circumstances, a voluntary, rationally requested, surgical incapacitation of procreation is not the commission of an act against the state. In fact, the federal government, through legislative and administrative programs, has overtly and positively moved to make family planning information available to married people and birth control measures information available to certain classes of unmarried individuals as well as married couples. Similar steps are now being considered by committees of the Wisconsin Legislature.

Furthermore, there appears to be no statutory or common law in this state indicating that the rendering of a person incapable of procreation, on a voluntary basis, is an act against the state.

State v. Arnold (1935), 217 Wis. 340, 258 N.W. 843, recited that sec. 151.15, Stats., which restricts the sale or dispensing of birth control *articles* or *devices* to married persons by a registered pharmacist or licensed physician, originally was introduced in the legislature as a prohibition against birth control, and, as such, failed to pass.

Griswold v. Connecticut (1965), 381 U.S. 479, 14 L. ed. (2d) 510, 85 S. Ct. 1678, is current and significant. In this case the Planned Parenthood League of Connecticut and its physician, who had offered information and medical advice on birth control to Connecticut citizens, were charged with a violation of a state statute prohibiting the use, possession, and sale of contraceptive devices. The Supreme Court held that this statute was violative of the Fourteenth Amendment to the U.S. Constitution. The majority concurring opinions emphasized individual rights and the essentially private nature of marriage, and held that a state statute interfering with or disrupting these rights or relationships was unconstitutional. Mr. Justice Douglas, speaking for the majority, stated (p. 485):

> "The present case, then, concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. And it concerns a law which, in forbidding the *use* of contraceptives rather than regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon that relationship. Such a law cannot stand in light of the familiar principle, so often applied by this Court, that a 'governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.' * * *"

Justice Goldberg stated in a concurring opinion that (pp. 485–496):

> "Although the Constitution does not speak in so many words of the right of privacy in marriage, I cannot believe that it offers these fundamental rights no protection. The fact that no particular provision of the Constitution explicitly forbids the State from disrupting the traditional relation of the family—a relation as old and as fundamental as our entire civilization—surely does not show that the Government was meant to have the power to do so. Rather, as the Ninth Amendment expressly recognizes, there are fundamental personal rights such as this one, which are protected from abridgment by the Government though not specifically mentioned in the Constitution."

In conclusion, it is my poinion that a doctor performing a sterilization operation, as defined, at the

[2] See R.S. 1849 c. 133 §31; R.S. 1858 c. 164 §31; R.S. 1878 §4372; St. 1925 §340.35.

R.S. 1849 c. 133 §31 reads, in part: "If any person, with malicious intent to maim or disfigure, shall cut * * *."

[3] *Ed. Schuster & Co. v. Steffes,* (1941) 237 Wis. 41, 295 N.W. 737.

voluntary rational request of a patient is not committing a crime under Wisconsin law.

Sincerely yours,

/s/ Bronson C. La Follette
Attorney General

Note: The foregoing opinion relates only to the criminal law of the State of Wisconsin and specifically refrains from discussing any aspects of civil law. Legal counsel for the State Medical Society call to your attention the fact that there is no statutory or case law in Wisconsin authorizing or prohibiting the performance of a nontherapeutic sterilization, except for certain institutional inmates. Therefore, it would appear that such surgery can be legally performed when based upon sound medical judgment, performed with due skill and care, and preceded by the informed signed consent of the patient and spouse, if married. In the case of a minor and in the absence of a medical emergency, court approval is recommended before performing such surgery.

PLACEMENT SERVICE AIDS DOCTORS AND COMMUNITIES

Do you want an associate? Generalist or specialist? Call 257–6781, area code 608; or write Box 1109, Madison, Wisconsin 53701.

The Placement Service of the State Medical Society has helped many physicians find a new assistant, found promising locations for young practitioners, and brought resident medical service to many communities without a doctor.

Here is how the Placement Service may be able to help you. The Society maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Usually there are 125 to 150 physicians listed in all categories. The Society also maintains a list of physicians and communities offering opportunities in individual, group, and other types of practice. The Wisconsin Medical Journal offers a Physicians Exchange service each month at reasonable rates. Widows of deceased physicians who were members of the Society may use this service without charge.

Physicians who have used the Placement Service have described it as quite effective. Journal advertising, too, has proved highly successful.

One word of advice: Tell the Society of your needs as soon as possible. More time usually means better results.

"DETERMINATION OF NEED FOR MEDICAL EVALUATION IN DRIVER LICENSING"

A new attack has been launched on the problem of providing a more adequate method of determining the fitness of applicants for driver's licenses. The spearhead of the attack is a new guide, "Determination of Need for Medical Evaluation in Driver Licensing," just developed by the AMA Committee on Medical Aspects of Automotive Safety.

This guide, aimed at non-medical licensing authorities, suggests a screening procedure to be used on all license applicants, with only those seeming to present an unwarranted risk as drivers being required to have an examination by a physician. To do such screening effectively, lay licensing authorities will have to have medical advice and guidance. The Committee on Medical Aspects of Automotive Safety suggests that state medical association committees on automotive safety work very closely with state licensing authorities and also with county medical societies.

In addition to improving licensing procedures the AMA Committee feels that this new guide will go a long way toward eliminating agitation for legislation which would require medical examinations for *all* drivers, as well as that which proposes compulsory reporting by physicians of conditions in their patients which might make driving unsafe. Both of these principles have been opposed by the medical profession for many reasons, principally that they are unworkable. In addition, the compulsory reporting proposal is felt to interfere with the confidentiality of medical records as well as with the traditional physician–patient relationship.

"Determination of Need for Medical Evaluation in Driver Licensing" was published originally in the Mar. 4, 1968, issue of *The Journal of the American Medical Association*, and reprints were distributed to state medical associations. Individual copies may be obtained from the Committee on Medical Aspects of Automotive Safety, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

NOTES ON ETHICS

Contingent Fees and Medical Expenses

By JOHN BLAKESLEE, Chicago, Illinois

A CONTRACT for a reasonable contingent fee, where sanctioned by law, is permitted by Canon 13 of the Canons of Professional Ethics, but the client must remain responsible to his attorney for expenses advanced on his behalf (Formal Opinion 246). Canon 42 states: "A lawyer may not properly agree with a client that the lawyer shall pay or bear the expense of litigation; he may in good faith advance expenses as a matter of convenience, but subject to reimbursement." Therefore, any agreement by which the lawyer bears or pays the expenses of litigation, without an understanding that he will be reimbursed is improper (Formal Opinion 20).

The Committee on Professional Ethics of the American Bar Association has interpreted the permissive language of Canon 42 as applying to court costs, witness fees and expenses resulting from the conduct of the litigation itself, but not to expenses unconnected with the litigation although resulting from the client's injury (Formal Opinion 288). Telephone and hotel charges are not "expenses" within the meaning of Canon 42 (Informal Opinion 338). In accordance with the canon and the opinions of the Committee, it has become an established practice for many lawyers to advance court costs, filing fees, expenses of photographers and investigators, court reporters, accident reports and the like as expenses of litigation. Medical expenses that are considered to be expenses of litigation may relate to (1) pretrial medical reports and additional examinations of the client requested by the lawyer, (2) conferences between physician and lawyer to explain and review diagnosis, prognosis or treatment rendered, (3) research to elicit pertinent medical information in preparation for trial, and (4) the physician's time spent on depositions, answering interrogatories and in court.

These are "expenses of litigation" and may be advanced, but the question that bothers some lawyers is whether physicians' fees for services rendered to the client as a matter of course in treatment are subject to advancement under Canon 42. Treatment may continue over a long period and be closely related to evaluation studies made at the request of the lawyer. It is sometimes difficult to distinguish services rendered in treatment from those performed in preparation of litigation. Informal Opinion 664 treats this question:

> Since a proper diagnosis of the client's condition based upon consultations, examinations and observation and with reports thereon to the lawyer are necessary to enable the doctor to testify as a witness in the case and to enable the attorney to appraise the value of his case, and to conduct a proper examination of the doctor should the case be tried, it is the opinion of the Committee that a lawyer may properly agree to pay the doctor's charges for such diagnostic work, under agreement with the client that the lawyer would be reimbursed therefor.
>
> Our committee is of the view . . . that it would not be proper for the lawyer to agree to pay the physician's fees for treatment of the client since this would not be an expense of litigation (except possibly to the extent that such treatment, and the response thereto, might be an essential part of the doctor's work in properly diagnosing the injuries and the extent thereof).

An attorney often requests his client's physician or a specialist to perform certain medical services that will enable the lawyer properly to evaluate the case. The physician may not question the lawyer about his fee, assuming that since the lawyer has requested the services, the lawyer is personally responsible for payment or will see to it that the physician is compensated. Unless the lawyer has made it clear that he is not personally responsible, it may be that he inadvertently has entered into an implied contract. The Ethics Committee considered this problem in Informal Opinion 664:

> In any given case a question of fact may arise as to whether or not the lawyer has expressly or implicitly agreed to pay the doctor's fee. If the lawyer merely gave the client the doctor's name and the client made the only contact with the doctor, even though he was requested to send reports to the lawyer, the lawyer might well take the position that he had not in any way agreed to pay the doctor's fee. On the other hand, if the lawyer contacts the doctor and requests him to do the diagnostic work and furnish the reports, it would seem that there is an implied agreement that the lawyer would pay for the work.

If the lawyer has no agreement or understanding with the client for reimbursement, he may find that his legal obligation conflicts with his ethical obligation.

Reprinted with permission from American Bar Association Journal, July 1968.

Mr. Blakeslee was an Assistant Director of Committee Activities of the American Bar Association assigned to the Committee on Professional Ethics at the time this article was written; however, this article is unofficial.

While it is proper for a lawyer to endeavor to persuade the client to pay known prelitigation medical bills, it is not his professional responsibility to see that these charges are paid from funds received as a result of the litigation. Neither may a lawyer personally guarantee the doctor's expenses in connection with the litigation if they are not or cannot be paid by the patient (Informal Opinion 1005). A lawyer is not his client's financial guardian, and it would be unethical for a lawyer to inform a physician that a case has been settled or a judgment obtained unless the client's permission to proceed in that fashion has been obtained in advance (Formal Opinion 163).

What the Lawyer Can Do

Questions and problems that arise from the payment of medical expenses are the focal point of much friction between the medical and legal professions. The American Medical Association Liaison Committee to the American Bar Association and the American Bar Association Committee To Cooperate with the American Medical Association advise that when an attorney first contacts a physician he should inform him specifically what it is he wants and clearly indicate how the physician will be compensated. If the fees are to be paid from the proceeds of any settlement or judgment, the lawyer should unequivocally inform the physician that only the client is responsible for payment in the event there are no proceeds forthcoming. Then the physician will have full information on which to decide whether he cares to proceed. He should not be required to deal at arm's length with members of another profession in order to obtain adequate information as to the source and likelihood of eventual payment.

The lawyer should at least obtain his client's authorization to pay all medical bills from the proceeds of a judgment or settlement, including treatment costs. Most physicians appreciate this and understand that the lawyer is not personally responsible for treatment expenses unrelated to litigation. However, if an effort is not made initially to communicate this clearly to the physician, it is likely that difficulties will develop later and the ethical issues will be lost in a cloud of disagreement and misunderstanding.

It may be questioned that many physicians will be willing to invest their time and talents on a medicolegal problem if they know they must rely for compensation solely on an uncertain settlement or judgment. This may not be an important consideration as to those expenses for treatment of an injury, but for all other services of the physician it is important. Changing times, an increased awareness on the part of the physician of the economic factors of the practice of medicine and the involvement of more physicians in medicolegal matters are bringing about a change in the physician's attitude. He is now well aware that in the event a case is lost, all too often the client either cannot pay or refuses to pay for a lost cause.

The American Bar Association's Canons of Professional Ethics and Canons of Judicial Ethics appear in Volume III of the 1968 edition of the *Martindale-Hubbell Law Directory*, pages 187A–200A. A pamphlet containing the canons is available without cost (and in quantities to bar associations and law schools) from the Committee on Professional Ethics, American Bar Association, 1155 East 60th Street, Chicago, Illinois 60637.

The Burden of Payment

If the client, on whom the burden of payment for litigation expenses rests, cannot or will not pay, then either the lawyer or the physician must bear the burden. It is difficult for physicians and many lawyers to understand why some lawyers advance expenses for filing fees and investigations but refuse to make advancements to physicians in appropriate situations. In addition, the physician knows that the attorney has an interest in the case by virtue of his contingent fee. Regardless of the justification of the contingent fee, it does give the lawyer a financial interest in the case. The physician, therefore, may resent expending his time and professional skill so that the lawyer's chances of collecting a fee are improved. He may also reason that his participation in a case could have terminated at a much earlier point, with no resulting medical disadvantage to his patient, if he had known that difficulties would arise in connection with his compensation.

Fair dealing and interprofessional harmony dictate a reasonable approach. Writing in the September 25, 1967, issue of the *Journal of the American Medical Association*, Richard P. Bergen, Director of the Legal Research Department of the A.M.A., states that if the attorney requests only a report from the physician on his patient, the physician should be willing to prepare a simplified, routine report without additional charge, as his fee for patient care usually is deemed to cover this work. However, if more than a routine report is requested, the physician should be compensated. Although legal ethics do not require the lawyer to pay the physician for expenses related directly to litigation, they do permit it. For lawyers to advance those medical expenses directly related to and arising because of the litigation, subject to reimbursement, is consistent not only with the canons but also with the practice of many lawyers as to all other such expenses. Ordinarily these expenses will not be large, except when the testimony of several specialists may be required at trial. In hardship cases, a physician should be willing to serve as a medical witness or evaluator without a guarantee that he will be paid, Mr. Bergen declared, and if he feels that justice will otherwise be defeated, he should be willing to provide medicolegal services without an assurance of compensation.

There are several factors that indicate it is reasonable to place this burden on the lawyer. Generally, he contacts the physician and sets the stage for their future relationship. He sets the terms of his employment with the client and can make provision for the advancement and reimbursement of expenses. He has charge of the disposition of funds at settlement or after judgment and is in touch with the client throughout the proceedings. The lawyer can suggest, in appropriate situations, that the client deposit a set sum each week (or payday) to cover the expenses of litigation.

Some Corrective Measures

Following the adoption of the National Interprofessional Code for Physicians and Attorneys by the American Medical Association and the American Bar Association in 1958, many state and local bar associations and medical societies have drawn up codes of conduct relating to interprofessional relations. Unfortunately, some of these codes go beyond the Canons of Professional Ethics. Generally, they recognize the physician's right to be compensated for his services, hut some place the primary responsibility for payment on the lawyer. Most set forth the procedure to be followed by members of both professions when it is necessary to use the services of a physician in connection with litigation and contain provisions respecting the settlement of disputes as to the reasonableness of the physician's charges. Since under legal ethics a lawyer cannot agree to pay or be responsible personally for payment of these expenses, the Association's Ethics Committee has suggested that local committees consider simply following the national code, copies of which are available from the American Bar Association.

Problems between lawyers and physicians will continue, but many potential ones can be avoided by using common professional courtesy and fair dealing. A method by which closer cooperation and understanding can be developed is the establishment of a committee of members of the local bar and medical society. This committee can entertain and hope to resolve grievances arising between members of the two professions. It is also a proper and appropriate vehicle for the speedy resolution of problems. Its existence will tend to draw members of both professions into a closer relationship, with a resulting benefit to the public whom we both serve.

The committee should be charged with organizing programs for joint meetings of the professions. Frank and open discussions would tend to reduce the friction that sometimes separates the professions. There is ample material available for programs. One suggestion is a showing of *The Medical Witness*, an excellent film suitable for a medicolegal audience. This film is one of a series produced by the Wm. S. Merrell Company, in co-operation with the American Bar Association and the American Medical Association, and demonstrates proper techniques and methods for both lawyers and physicians. (Information on this and other suitable films may be obtained from the American Bar Association Public Relations Department.) In addition, *Proceedings of the 1967 National Medicolegal Symposium* contains a wealth of material suitable for program adaptation. It is available at $5 per copy from the American Bar Association.

WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

ALCOHOL FOUND IN BLOOD OF MOST DRIVERS KILLED ON ROAD

Alcohol was present in the blood of 73% of the drivers killed on Wisconsin roads and reported during the first three months under the new highway safety law. Analysis showed that 30% of these drivers had more than .150% alcohol by weight in their blood. This, by Wisconsin law, is prima facie evidence that the person was under the influence of an intoxicant. Reporting during the first weeks was not complete but the ratios changed little during the quarter.

The law which became effective Jan. 11, 1968, provides that the coroner is responsible for obtaining a blood specimen from the driver of a motor vehicle or a pedestrian 16 years of age or older who died within 6 hours of the time of the accident. The blood samples taken are sent to the State Laboratory of Hygiene for analysis of the alcohol content.

Figures in first reports top the estimate of the National Safety Council which in its 1966 Accident Facts said, "Drinking may be a factor in as many as half of the fatal motor vehicle accidents."

The Wisconsin figures also top those cited in a more current report, written by Horace E. Campbell, MD, of Denver in the Apr. 8, 1968, issue of HOSPITAL TRIBUNE, who said, "It is now clear that the problem drinker constitutes about two-thirds of our drinking driver problem."

The extent that alcohol is a factor in fatal accidents, including auto fatalities is cited in a different way by Berthold Brenner of the National Institute of Mental Health. He found in a recent study that alcoholics were four and one-half times as likely as non-alcoholics to meet death as a result of a motor vehicle accident.

"How many of Wisconsin's 129,000 known alcoholics will be killed and how many others will be killed by them in motor vehicle accidents this year?"

Reprinted from the *Wisconsin Medical Journal*, July 1965
at the request of the Division on Maternal and Child Welfare

Nurse Responsibility in Maternal and Child Care

EXPLANATORY PREFACE: As an outgrowth of the Wisconsin Maternal Mortality Survey, the State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments, with Council approval, initiated an ad hoc study, with representatives from the Division, the Wisconsin Hospital Association, and the Wisconsin Nurses Association serving on the special committee.

The report of this committee is given below. The statement has been approved by the House of Delegates of the State Medical Society, by the Wisconsin Hospital Association, and by the Wisconsin Nurses Association.

It is important to explain that these are recommendations, and not directives. Each medical staff, in conference with nurses and hospital administration, has been urged to implement these recommendations in light of local resources and needs. The Division hopes that each hospital will review its existing rules and incorporate as many of these recommendations as possible.—JOHN R. EVRARD, M.D., Chairman, Division on Maternal and Child Welfare.

■ WITH THE CONSTANT change in medical, nursing, and hospital services to mothers and children, misunderstandings and misinterpretations relating to practice have arisen between the various disciplines providing service. This Ad Hoc Committee, representing medical, nursing, and hospital groups, was established at the suggestion of the Maternal Mortality Study Committee (a subcommittee of the Division on Maternal and Child Welfare of the Commission on State Departments) to review selected responsibilities which nurses are being asked to assume, and to make recommendations.

It was directed to give primary attention to safeguarding the welfare of mothers and children. Also to bear in mind that "*diagnosis and treatment*," as defined by law, are the responsibility of the physician and *cannot be assumed by the nurse* and, that the practice of nursing, also defined by law, may or may not permit nurses to perform certain procedures heretofore considered medical practice. If the nurse can accept these responsibilities, what instruction is needed so as to safeguard the patient, physician and nurse?

Analgesia and Anesthesia

The giving of an anesthetic agent to an obstetric patient creates hazards both from the anesthetic agent and aspiration of vomitus. Deliveries sometimes occur when an anesthetist is not available, and nurses are being asked to assume responsibility in the administration of anesthesia for which they are not prepared.

Recommendations of the Committee

1. The most qualified individual available should administer anesthesia. This includes the anesthesiologist, the Certified registered nurse anesthetist and, if in accordance with local practice the physician having knowledge of anesthesia.
2. If an anesthesiologist, Certified registered nurse anesthetist, or physician having knowledge of anesthesia is not available to administer the anesthesia, a Registered nurse who shall have been properly instructed* may administer inhalation anesthesia under the direct supervision of a physician having knowledge of anesthesia, if it does not produce a surgical plane of anesthesia and does not eliminate protective reflexes (swallowing and coughing).
3. Self-administered analgesia by the patient should be used only on written or telephone order of the physician, *under direct bedside supervision of a properly instructed* person*, and under the supervision of a Registered nurse.
4. Trichlorethylene (Trimar, Trilene) should be self-administered *by the patient only*, and should not be followed by the use of carbon dioxide-soda lime absorption technique to administer an anesthetic agent.
5. Local and spinal anesthesia should be given by the physician.
6. Resuscitation of infants is the primary responsibility of the physician, with the help of properly instructed* assistants.

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*"Properly instructed" indicates a course of instruction, demonstration, and supervision meeting criteria established jointly by the medical staff, anesthesiologist and Certified registered nurse anesthetists, nursing staff, and hospital administration, covering the administration of anesthetic agents, the maintenance and care of patient's airway, and administration of artificial respiration with anesthetic bag and mask. The qualification for such instruction would be

(a) designation of a specific person as instructor who is qualified to teach the above mentioned techniques
(b) course be in writing and approved by the executive committee of the medical staff and hospital administration
(c) a record be made and signed that the individual nurse has been properly instructed.

Intravenous Fluids and Blood Transfusion

Intravenous fluids and blood transfusions have become accepted means of saving lives in case of hemorrhage. The time element is a very important factor in getting a large enough needle into a rapidly collapsing vein.

Recommendations of the Committee

1. A written policy for having and obtaining compatible blood and having emergency intravenous fluids for every patient should be established jointly by medical and nursing staffs, laboratory personnel, and hospital administration. The following should be considered in the criteria.
   a. Every patient should have an Rh determination in the ante partum period and this information made available to hospital personnel on or before admission to hospital.
   b. Hospital personnel on all shifts should have knowledge of and ready access to sources of blood and fibrinogen.
   c. Only a physician may do a cut down.
   d. *In an obstetric emergency* a Registered nurse (who shall have been "properly instructed"*) may start intravenous fluids, e.g., 5% glucose in distilled H_2O or fluids established by each hospital's medical staff, without obtaining a specific order by the physician. *In case of severe hemorrhage* the Registered nurse (who shall have been "properly instructed"*) may administer properly typed and cross matched or Type O Rh negative blood (never a blood expander) without a specific order by the physician.
   e. A Registered nurse who shall have been properly instructed* may administer properly typed and cross matched blood on the physician's written order.
   f. The administration of blood should be under the direct supervision of a physician or Registered nurse at patient's side for at least the first 15 minutes. The patient should be checked regularly, as indicated by the condition of the patient, until the transfusion is completed.
   g. If any adverse symptoms occur, the Registered nurse must stop the flow of blood and notify the physician and laboratory immediately.

* "Properly instructed" indicates a course of instruction, demonstration and supervision meeting criteria established jointly by the medical and nursing staff, laboratory personnel, and hospital administration, covering the administration of intravenous bloods and fluids; the proper checking of blood, amount to be given and rate of flow, vital signs and symptoms (TPR, BP, etc.); reaction symptoms that might occur (abdominal pain, chills, etc.); emergency measures that might be required before the physician arrives; and follow-up measures upon completion of transfusion (BP, etc.). The qualification for such instruction would be

(a) designation of a specific person as instructor who is qualified to teach the above mentioned techniques
(b) course in writing and approved by the executive committee of medical staff and hospital administration
(c) a record be made and signed that the individual nurse has been properly instructed.

Injections and Immunization

Some persons have untoward reactions to many of the common drugs and biologicals. The following recommendations are concerned with these possible reactions to drugs or biologicals, rather than the act of giving the immunization or injection by the nurse. Each injection should be individualized. Recognizing that this may be difficult in mass immunization clinics, provision should be made for at least minimal screening by a responsible adult, parent, teacher, nurse, or physician.

Recommendations of the Committee

1. IMMUNIZATIONS
   A. Public Health Immunization
      Because of the possibility (even if remote) of individual reactions to biological agents used, the following criteria should be established:
      (1) The immunization clinic should be conducted according to written order of the local health officer (if a physician) or the County Medical Society specifying type of injections, age groups, materials and dosage, medical coverage, and referral procedure.
      (2) A physician should be in attendance at the clinic site so long as injections are being given.
      (3) A Registered nurse, properly instructed†, may give the injections *if a physician is in attendance at the clinic site.*
   B. Industrial Health and Employee Health Programs
      (1) A physician should be in attendance at the clinic site so long as injections are being given.
      (2) A Registered nurse, properly instructed†, may give the injections *if a physician is in attendance at the clinic site.*
   C. In the Physician's Office
      The office nurse is an employee of the physician and is his legal responsibility. He should see that she shall have been properly instructed† and gives injections only on written general or specific orders.
   D. Mass Screening for Tuberculosis
      Same basic principles outlined under A., with the exception that a Registered nurse, properly instructed†, may conduct these clinics with or without a physician being present.

† "Properly instructed" indicates a course of instruction, demonstration, and supervision meeting the criteria established jointly by medical and nursing groups, covering the administration of drugs or biologicals (intramuscular, intradermal, etc.), untoward reactions, contraindications for use of drugs or biologicals, precautions, and follow-up. The qualification for such instruction would be

(a) designation of a specific person as instructor who is qualified to teach the above mentioned techniques
(b) course be written and approved by the executive committee and the medical and nursing staff
(c) a record be made and signed that the individual nurse has been properly instructed.

2. Injections

A. The Pharmacy Committee of the hospital or local medical group should make a list of drugs used in treating the sick that require a physician's presence.

B. Except for those drugs listed by the Pharmacy Committee, a Registered nurse or Trained practical nurse may give injections upon the written order of the physician specifying the name of the patient, the medication, dosage, time of dosage, etc.

C. A Registered nurse experienced in vena puncture may give certain intravenous medications on written order of a physician. The Pharmacy Committee should list medicines that require a physician's presence.

Vaginal Examinations

These recommendations supplant the statement of the Wisconsin Mortality Study Committee, Wisconsin Medical Journal, January 1964, page 57.

Recommendations of the Committee

1. ROUTINE vaginal examination by Registered nurses on patients in labor is NOT RECOMMENDED.
2. Where the procedure has been approved by the medical staff, a physician should direct and permit a Registered nurse to perform such an examination only if she shall have been properly instructed.*

Oxytocics

The Maternal Mortality Survey and Study Committee, which is a subcommittee of the Division on Maternal and Child Welfare of the State Medical Society's Commission on State Departments, has been aware for the past several years that oxytocic substances, when used for the stimulation, acceleration or initiation of labor, have associated with their use for these purposes certain potential dangers, specifically that of occasionally causing rupture of the uterus.

Since rupture of the uterus constitutes an emergency of the most extreme import, that Committee has recommended to hospital staffs that when these substances are given for the above purposes the physician *(or an "adequate medical substitute"†)* be in attendance or within the hospital for *immediate contact*, and that the nurse be requested to administer these substances only under these conditions.

Since the potential danger of these substances applies to all of those being currently used, and to whatever route of administration, the recommendation is that they be administered by the Registered nurse only when the physician is physically present either at the locality where they are being given or in the immediate vicinity so that he can be reached in case that a serious emergency occurs.

In view of the serious nature of this problem, recommendations are:

1. Support for Wisconsin State Administrative Code H 26.063(2) which reads:
   "Oxytocics. Nurses or other non-medical personnel shall not administer oxytocics to antepartum patients unless a physician is present."
   a. This means oxytocics administered by *any* means—buccal, basal, oral, intramuscular, or intravenous.
2. Medication should be discontinued if the physician (or his "adequate medical substitute") is not *immediately available* (within the unit or hospital).
3. Only nurses who shall have been properly instructed‡ should stay with patients who are being medically induced in labor.

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* "Properly instructed" indicates a course of instruction, demonstration, and supervision meeting criteria established jointly by the medical and nursing staff and hospital administration, covering a technique for vaginal examination which will not introduce infection in birth canal, and when not to do vaginal examinations (bleeding, etc.). The qualification for such instruction would be

(a) designation of a specific person as instructor who is qualified to teach the above mentioned technique
(b) course be in writing and approved by the executive committee of medical staff and hospital administration
(c) a record be made and signed that the individual nurse has been properly instructed.

† "Adequate medical substitute" means a physician well enough versed in obstetrics to properly handle medical emergencies commonly resulting from adverse reaction to administered oxytocics.

(a) Intravenous drip is a much safer procedure than other methods of administration, and permits the best discontinuation of drug.
(b) Buccal is a new method of administration. In event of an adverse reaction the tablets should be removed and mouth thoroughly washed.
(c) Nasal pledgets should be removed, in event of adverse patient reaction.
(d) Intramuscular and oral are the least desired since the effects of drugs continue until dosage is absorbed.

‡ "Properly instructed" indicates a course of instruction, demonstration and supervision meeting criteria established jointly by medical and nursing staff and hospital administration, covering the effects of this drug upon the patient's labor and the necessity for checking pulse and respiration, blood pressure every 15 minutes, fetal heart every 5 minutes, and timing of duration, length and intensity of contraction. The qualification for such instruction would be

(a) designation of a specific person as instructor who is qualified to teach above mentioned techniques
(b) course be in writing and approved by the executive committee of medical staff and hospital administration
(c) a record be made and signed that the individual nurse has been properly instructed.

The Professional Corporation in 1968

I. HISTORY AND BACKGROUND

SINCE 1932, the Internal Revenue Code has contained, unchanged, statutory definitions of partnerships and corporations. They are as follows:

> "(2) PARTNERSHIP AND PARTNER.—The term 'partnership' includes a syndicate, group, pool, joint venture, *or other unincorporated organization*, through or by means of which any business, financial operation, or venture is carried on, and *which is not*, within the meaning of this title, a trust or estate or *a corporation;* and the term 'partner' includes a member in such a syndicate, group, pool, joint venture, or organization. (Emphasis supplied)
>
> "(3) CORPORATION.—The term 'corporation' includes *associations*, joint-stock companies, and insurance companies." (Emphasis supplied)

Until the beginning of World War II in the early 1940s, corporate income tax rates were high and individual income rates were relatively low. The revenue interests of the federal government during the 1930s were therefore best served by having as many organizations treated as corporations as possible. Accordingly, the Internal Revenue Service sought to treat as associations as many partnerships, including medical partnerships, as it could, so as to apply the higher corporate income tax rates instead of the lower individual rates.

In 1936, in the case of *Pelton v. Commissioner* (C.A.—7th), 82 Fed. 2d. 473, the Circuit Court of Appeals in Chicago upheld the contention of the Internal Revenue Service that an organization of physicians was an unincorporated association and should be treated as a corporation for federal income tax purposes, even though a corporation could not practice medicine in Illinois.

The Circuit Court of Appeals based its decision on the theory that the organization of physicians had in fact more of the characteristics of a corporation than it did a partnership. The four characteristics that it considered were: (1) the centralization of management, (2) the continuity of the partnership life, despite the death or withdrawal of one or more partners, (3), the limitation of personal liability for liabilities of the partnership, and (4) the right of the individual members of the organization to transfer freely their interests in it.

On the basis of the *Pelton* decision, a number of partnerships, voluntarily or involuntarily, were treated as associations and therefore taxed as corporations by the federal government.

World War II caused a switch in the federal income tax rates, and for the first time individual rates became higher than corporate rates. Concurrently, the 1942 Revenue Code, for the first time, recognized deferred compensation plans, such as profit sharing and pension plans, for employees. Officers or stockholders who were employed by corporations were allowed to participate in these plans the same as any other employee. The contributions to the plan which were made by the corporation on behalf of the officers or stockholder employees, were deductible as a business expense by the corporation on its income tax return, and the employee was not compelled to report such contributions as income currently on his income tax return.

The result of these changes in the federal income tax law, when coupled with the rationale of the *Pelton* case, now made it desirable for some medical groups to seek association status, and thereby achieve corporate income tax status and employee status for the physician members of the medical group.

In the now famous case of *United States v. Kintner*, (C.A.—9th) 216 F. 2d. 473, the Internal Revenue Service reversed its position and sought to tax the unincorporated association of physicians as a partnership, rather than as an association taxable as a corporation. The court, in that case, rejected the government's reversed position, cited the *Pelton* case with approval, and held that the association was taxable as a corporation. This case was decided in 1954.

In 1959, in *Galt v. United States*, 175 Fed. Supp. 360, (N.D.—Texas), the District Court again held an unincorporated association of physicians taxable as a corporation, despite the contrary arguments of the Internal Revenue Service. The Treasury Department was also unsuccessful in the *Foreman* case, which was tried in the District Court of Florida.

The Internal Revenue Service did not agree with or follow any of the decisions cited above, but instead, in 1959, attempted to amend the Code by issuing a set of proposed income tax regulations which would have the force of law, and the effect of making it practically impossible for the attainment of corporate status by medical partnerships. These regulations were finalized in November 1960, and were felt by most tax practitioners to be contrary to the interpretations of the Internal Revenue Code by the courts in the *Pelton, Kintner* and *Galt* cases.

These 1960 regulations in part provided that *local law* (state law) would be applied in determining the relationship of the professional person to his business organization. If an organization was a partnership under general state non-tax law, it would be a partnership for federal income tax purposes. Accordingly, professional organizations in more than 30 states went to their state legislatures and asked

for the adoption of state laws authorizing the formation of corporations and associations for the practice of their professions. These laws were expressly drawn so as to make it possible for a professional group to organize in such a manner that they could comply with these 1960 Regulations and thereby become taxable as corporations.

Wisconsin was one of the first states in which professional organizations sought and secured legislation in 1961. The professional corporation statute of this state requires that such a corporation provide for capital stock which may be held only by the members of the particular profession which organizes it. No person outside that profession is allowed to purchase any of its stock. All directors and officers of the corporation must be members of the same profession.

In reliance on these laws, corporations and associations were organized by professionals in these various states. It is estimated that about 100 professional corporations alone have been established in this state since 1961. Pension plans and profit sharing plans were adopted, and contributions were made to these plans by the associations and corporations. Many applications were made to the Treasury Department for approval of corporate status and approval of the profit sharing and pension plans. The Treasury took no action on any of them. Furthermore, several groups precipitated a legal test of the issue by filing partnership returns, paying the tax for the partners, and then suing for a refund. The Treasury did not defend these cases, but instead refunded the tax in question so that there would be no issue for the court to pass on.

Finally, in December of 1963, the Treasury Department proposed a whole new set of regulations, and these were finalized in February of 1965. The gist of the revised regulations is that no professional group which has organized under state statutes allowing professionals to form corporations or associations will be recognized by the Treasury Department as a corporation, and, therefore, the profit sharing and pension plan benefits will not be recognized for the professional person either. The new regulations did recognize as corporations, for federal income tax purposes, those professional corporations and associations which were organized and filed corporate income tax returns in 1964 and prior years.

Unlike the 1960 Regulations, which were directed at *un*incorporated associations, those of 1965 were directed at *in*corporated organizations, despite the clear language of the Revenue Code itself, which says

> "The term 'partnership' includes a syndicate, group, pool, joint venture, or other *un*incorporated organization . . . which is *not* a *corporation.*"

The first case involving professional corporations since the promulgation of these 1965 regulations has recently been decided by the Federal District Court of Colorado. The opinion in the case of *Empey v. United States* was dated August 31, 1967. The Court held the 1965 Regulations to be invalid, and did so by stating that the clear language of the Internal Revenue Code itself was that a partnership included only *un*incorporated organizations and that any *in*corporated organization must be treated as a corporation for federal income tax purposes. It also cited with approval the rationale and holdings in the *Pelton, Kintner, Galt* and *Foreman* cases.

The federal government has filed an appeal in the *Empey* case. Whether it will perfect its appeal remains to be seen.

The *Empey* case is, of course, not binding as a judicial precedent in the Wisconsin Federal District Courts, or in the 7th Circuit Court of Appeals, which hears appeals from Wisconsin district courts. Especially in the absence of contrary federal court decisions, it is reasonable to anticipate that the *Empey* case will be carefully considered by the federal courts of Wisconsin.

II. TAX BENEFITS OF PROFESSIONAL CORPORATIONS

1. Income Tax

Since all medical practice fees are paid to the professional corporation, this permits the corporation to pay *less than all* of its net income to the physician members, and to pay the balance to a separate tax-exempt profit sharing retirement trust. Thus the physicians do not have as much personal taxable income, and their individual income taxes are correspondingly reduced.

The balance of net income not paid to a physician member of a professional corporation is deductible for income tax purposes by the corporation when paid by it to the profit sharing trust.

Thus, no tax is paid on this balance and the tax saving to the physician is whatever his top income tax bracket would have been had he received this sum instead of having it paid by the professional corporation to the profit sharing trust.

The amount paid by the corporation to the tax exempt profit sharing trust must be allocated to all, or nearly all, employees, including others than physicians. But, because this allocation can be made in the ratio of the respective salaries received by the employees including physicians, the physicians having by far the greater percentage of these aggregate salaries, also have by far the greater percentage of profit sharing trust contribution allocated to them. Thus, while the tax saving is somewhat diluted by this allocation to nonphysician employees, the greater part of the tax saving continues to inure to the benefit of the physicians who comprise the professional corporation.

As a broad generalization, a successful professional corporation will generate income at suffi-

ciently high levels so that there is likely to be some saving in Wisconsin income taxes as well as in the federal. The state saving will typically be substantially less, but should not be minimized.

In addition, the profit sharing trust being itself tax exempt, all capital gains and all interest and dividend receipts of the trust are income tax exempt.

The benefits are taxed when received from the profit sharing trust by each employee at time of his retirement, or severance of employment, or by his beneficiaries at time of death. However they can be taxed at no higher than 25% of the benefits, this being treated as long-term capital gains if all of the benefits are received in one year. The income tax benefits of a profit sharing trust, as compared with private investing can be illustrated best by the approximate figures shown in the following computation:

Comparison of Privately Investing $1,000 (Reduced by Income Tax) Annually Compounded at 4%, with Investing $1,000 Annually in a Profit Sharing Plan Compounded at 4%

Number of Years	Investment in Profit Sharing Trust		Less Capital Gain Tax		Net	Private Investment Various Tax Brackets 50%	60%
5	$ 5,400	less	$1,350	=	$ 4,050	$ 2,500	$ 2,000
10	12,000	less	3,000	=	9,000	5,400	4,250
15	20,000	less	5,000	=	15,000	8,500	6,600
20	29,000	less	7,250	=	21,750	12,100	9,200

2. Death Tax

In addition to the income tax benefits described above, a substantial death or estate tax benefit is also available. Any benefits paid by the profit sharing trust upon the death of an employee to his beneficiaries is exempt from the federal death tax. The typical physician's estate will have a federal estate tax bracket of about 15% if he has a surviving wife, or approximately 30% if his wife has predeceased him.

By way of example, if the benefits paid to the deceased physician's beneficiaries amount to $100,000, the saving in federal death tax alone would amount to either $15,000 or $30,000, as the case may be.

III. PROFESSIONAL CORPORATIONS vs. H.R. 10 (KEOGH LAW) SELF EMPLOYED PLANS

While H.R. 10 self employed profit sharing and pension plans do provide some tax benefits, there are major features of professional corporation profit sharing and pension plans which are not available under the H.R. 10 self employed type plan.

The maximum amount which can be contributed for any one owner employee in an H.R. 10 plan is $2500, or 10% of earned income, whichever is less. In a professional corporation profit sharing plan, the limitation is 15 percent of the employee's compensation, no matter how high the compensation goes. For example, in a professional corporation profit sharing plan a physician whose salary from the professional corporation was $50,000 per year could have $7500 contributed, tax free, to the plan, whereas he would be limited to $2500 under H.R. 10.

Second, capital gains treatment of benefits on severance of employment or death, is not available in H.R. 10 plans. Instead an averaging device is substituted, which, depending upon a number of other factors, will produce a result somewhere between ordinary income treatment and capital gain treatment.

The death benefits paid from an H.R. 10 plan are not exempt from federal death tax as they are in the case of a plan created by a professional corporation. There are a number of other differences which make the H.R. 10 plans somewhat less desirable. Furthermore, the method of operation with regard to H.R. 10 plans is much less flexible even during the years during which the employee is working before retirement.

IV. EFFECT IF CORPORATE STATUS NOT ACHIEVED

If the corporation were ultimately treated by Internal Revenue Service and the courts as a partnership, a major effect would be that the contributions made to the profit sharing trust by the corporation for the benefit of the physician employees would not be deductible by the corporation but instead would be treated as having been just as though the corporation were a partnership and therefore these contributions to the plan would be taxed to the individual physicians. A tax would therefore be payable on these contributions. Insofar as this tax is concerned, however, the taxpayer would be no worse off than he would have been had he not set up the profit sharing plan in the first place.

Interest, however, is payable on any tax determined to be due which is not paid on time. A three year statute of limitations is in existence, and interest at the rate of 6% is chargeable. The interest is on the amount of tax, not on the amount of the profit sharing contribution. The real effective rate, after tax, of interest in the case of a 50% top bracket income taxpayer is only 3%, interest being a deductible item.

Furthermore, the corporation would have spent money for legal and accounting fees in setting up the corporation and profit sharing plan. These, however, should also be deductible as abandoned reorganization expenses, so that the real cost to a 50% taxpayer would only be 50%.

There would be of course litigation expense if the professional corporation and its physician-employees chose to fight the matter of professional corporation status.

Lastly, the lay employees' accounts in the profit sharing trust would be fully vested and could not

be returned to the corporation or the physicians. In effect the employees would have gotten a raise in compensation which they keep.

V. TO INCORPORATE OR NOT TO INCORPORATE?

It would seem that whether or not to incorporate is a business decision. In making this decision, each medical group must compute (a) its annual tax benefits, (b) the projected death tax savings, and (c) tax-free compounding of earnings, and weigh these against what they will stand to lose in the way of interest and litigation costs which will be payable if the matter is contested.

As a broad generalization, the creation of a professional corporation is probably not warranted unless there is strong likelihood that the income generated, barring ill health or other similar contingencies, will produce a surplus beyond the reasonable needs of the organizers. If, for reasons of personal need or preference, those earning the income desire to spend it all, the profit sharing savings device which is so important a part of the professional corporation would have no useful function to serve.

If the economic gain possibilities substantially outweigh the costs of litigation and interest, it would seem that professional incorporation would be a good business risk. Each group, however, should make its decision on whether to incorporate only after a painstaking analysis of the overall situations of all physicians involved.

If it can be assumed that most courts will uphold corporate income tax status for professional corporations on the basis of finding the regulations invalid, and that an organization which is called a corporation by state legislature shall be taxed federally, as a corporation, then it would seem that the sole practitioner and the two physician partnerships should also have no features which would make incorporation for them any more risky taxwise than for groups of three or more.

EDITOR'S NOTE:

Attorneys for the Society have advised that 4 more U. S. District Courts have decided in favor of taxpayer professional corporations and against the Treasury during 1968. To date all decisions have been in favor of the taxpayers. Counsel also reports that more than 20 other cases are known to be pending in various parts of the country involving the validity of the U. S. Treasury regulations on professional corporations. Thus far no decision has been announced in the appeal taken in the *Empey* case, the 1967 decision, which is discussed on page 16 of this article.

RECENT CHANGES IN SELF-EMPLOYED RETIREMENT PLANS

Beginning January 1, 1968 a self-employed person can set aside 10% of his annual earnings or $2,500.00, whichever is less, to a qualified retirement plan. He may deduct his entire contribution. Previously only 50% of the self-employed person's contribution could be deducted.

One of the requirements of a self-employed retirement plan is that the self-employed individual must make contributions for all full-time employees with three years' service. The Internal Revenue has ruled that full-time employees who have worked for three years for physicians who shared the employees (no partnership) are employees of *all* the physicians for purposes of a self-employed retirement plan. If one of the physicians set up a retirement plan, he would have to make contributions for *all* of the shared employees. Thus, the cost of a self-employed retirement plan might be extremely prohibitive to the physician who shares employees with other physicians.

MALPRACTICE DEFINED

MALPRACTICE . . . Section 147.22 of the Wisconsin Statutes, quoted below, is concerned with the legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 147.22 reads as follows:

> "Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the afflicted without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

The Right to Use the Title "Doctor" in Wisconsin

HISTORICALLY, the title "doctor" has been conferred upon those who have become so well versed in a particular field of knowledge that recognized schools of higher education regard them as qualified to teach the subject. Among the long-established doctoral degrees are those in medicine, dentistry, divinity, law, science, philosophy, letters and music.

TRADITIONALLY, when the treatment of the sick was involved, the title "doctor" has referred to the doctor of medicine.

The legal right to use the title "doctor" outside the field of treating the sick is not discussed. Obvious examples are doctors of divinity, veterinary medicine, or philosophy, so long as none of them is engaged in "treating the sick," as this term is defined in Wisconsin.

THE WISCONSIN statutes and court interpretations are controlling on who may use the title "doctor" when "treating the sick."

The following is a summary of the present law of Wisconsin as it applies to use of the title "doctor" when engaged in "treating the sick." This is accompanied by brief references to the legal authority supporting the conclusions. It is assumed in each instance that the practitioner has fulfilled licensure or other requirements imposed by Wisconsin law.

Subsections (a) and (b) of Sec. 147.01 (1) of the Wisconsin Statutes, 1967, provide:

> "(a) To "treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.
>
> (b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

LEGAL AUTHORITY

The following is a summary of the principal statute or court decision which is the basis of the conclusions reached in the chart below and which follows the same order as the chart:

1. **Physician:** The right of a doctor of medicine to use the title without restriction is conferred by Sec. 147.14 (3), Wisconsin Statutes, which provides:

> "(3) No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under s. 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M.D." "D.O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick."

2. **Osteopath:** Controlled by the above subsection and, therefore, unlimited.

3. **Dentist:** The right of a licensed doctor of dental surgery to use the title without restriction is conferred by Sec. 152.02 (1), Wisconsin Statutes, which provides in part:

> "(1) Any person who was lawfully engaged in the practice of dentistry in this state on January 1, 1939, may so continue if he has registered annually. . . . No other person shall practice dentistry in this state, unless he is licensed by the board and annually registered in this state. . . . Any person is deemed to be "practicing dentistry"

SUMMARY OF WISCONSIN LAW ON USE OF TITLE "DOCTOR"

Practitioner	Unrestricted Right to Public Use	No Right to Public Use When Treating Sick
1. Physician	X	
2. Osteopath	X	
3. Dentist	X	
4. Podiatrist (Chiropodist)	X	
5. Chiropractor		X
6. Optometrist		X
7. Doctor of Philosophy (when treating the sick)		X

within the meaning of this chapter who . . . uses or permits to be used, directly or indirectly, for a profit or otherwise for himself, or for any other person, the title or appends to his name the words or letters "doctor," "Dr.," "Doctor of Dental Surgery," "D.D.S.," or "D.M.D.," or any other letters, titles, degrees, terms or descriptive matter, personal or not, which directly or indirectly represent him to be engaged in the practice of dentistry. . . ."

4. **Podiatrist:** (Chiropodist) The right of a registered podiatrist to use the title without restriction is conferred by Sec. 154.01 (2), Wisconsin Statutes. This provides in part:

"(2) No person shall practice podiatry, for compensation, directly or indirectly, or in the expectation thereof, or attempt to do so, or designate himself as a licensed podiatrist, or use the title "D.S.C.," "Dr.," or "Doctor of Surgical Chiropody," or "Doctor of Podiatry," or "Doctor," or "foot doctor," or "foot specialist" or other title or letter indicating that he is a podiatrist, or otherwise directly or indirectly represent or hold himself out as such, unless registered by the state board of medical examiners . . ."

5. **Chiropractor:** No statute relating to chiropractic authorizes the use of the title "doctor" or initials "Dr." or "D.C." by a chiropractor. The illegality of the use of either the title or the initials "D.C." is based upon Sec. 147.14 (3) quoted earlier in Section 1. of this article, inasmuch as chiropractors "treat the sick."

In *State v. Michaels* (1938) 226 Wis. 574, the Supreme Court, in an opinion written by Chief Justice Rosenberry, forbade a chiropractor to use the title "doctor." The opinion stated, at pages 578 and 579, that since 1881 the use of the word "doctor" had been restricted by the Wisconsin legislature, and that the right to use the term had become associated with those entitled to practice medicine, surgery, and after 1903 osteopathy.

With reference to the statute regulating chiropractic, which was amended in 1925 to require licensure, the court stated at page 579 of the above opinion:

"The statute was rewritten and revised to make it clear that those practicing chiropractic could not hold themselves out as a doctor or append to their names the title of doctor because, in Wisconsin at least, that would tend to represent them as a doctor authorized to practice medicine, surgery, or osteopathy."

6. **Optometrist:** An optometrist practicing in Wisconsin is *not* entitled to use the word "doctor," the title of "Doctor of Optometry," or the initials "O.D." in the course of his practice. Chapter 153 of the Wisconsin Statutes deals with optometry. It is completely silent on his right to use the title or any variation of it. Authority must, therefore, be sought outside that chapter. In *Nickell v. State* (1931) 205 Wis. 614, at pages 617–618, the Supreme Court held that the examination of human eyes by various mechanical means constituted "treating the sick" under the Wisconsin Statutes. That decision has not been modified by subsequent opinions of the Supreme Court, or by later legislation. The essence of the practice of optometry is the examination of human eyes by such mechanical means. Therefore, the use of the title is controlled by and forbidden under Sec. 147.14 (3), Wisconsin Statutes, quoted in Section 1. of this article.

7. **Doctor of Philosophy:** There is no Wisconsin court decision authorizing *any* doctor of philosophy, including a psychologist, to make public use of his title when treating the sick. It is clearly controlled and prohibited by the provisions of Sec. 147.14 (3) quoted in Section 1. of this article.

As the Rosenberry opinion stated so appropriately as to the use of the title "doctor" by chiropractors in the *Michaels* case, cited in Section 5. of this article, at page 580 of that decision:

"The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment."

In the somewhat earlier case of *Corsten v. Industrial Commission* (1932) 207 Wis. 147, the court concluded its discussion of the meaning of Sec. 147.14 (3), quoted earlier, with the following sentence which appears at page 149 of the decision:

"Thus these names and letters may be applied only to those who are licensed as physicians to practice medicine and surgery, and conversely those to whom the names and letters may not be applied are not physicians."

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Sections 155.05 and 966.121, Wisconsin Statutes, 1967.

What Every Doctor Should Know about Workmen's Compensation

VIRTUALLY every physician practicing in Wisconsin becomes involved with treatment of a patient covered by Workmen's Compensation. This law provides payment of compensation for disability and expense for medical attention necessary because of injury sustained in the course of and arising out of employment.

Please contact either the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, or Ralph E. Gintz, Administrator of the Workmen's Compensation Division, Hill Farms State Office Building, Box 2209, Madison, Wis. 53701, if you have any questions.

Five points of advice will aid every physician in dealing with Workmen's Comp.:

★ Have your name listed on the State Medical Society's Workmen's Compensation panels if you want to treat employes under Workmen's Compensation.

★ Learn how to estimate disability according to the standards set up by the Department of Industry, Labor, and Human Relations (formerly the Industrial Commission). Other standards or schedules are fine for your own information, but only the Department's standards are authoritative in Wisconsin.

★ Submit your reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. Quite often the unexpected misfortune places the employe in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society or Ralph E. Gintz at the addresses noted above.

The following article provides answers to the questions most commonly asked of the State Medical Society in its past 32 years of experience with the Workmen's Compensation Act.

Q. Since the Workmen's Compensation Act is designed to provide protection to the working men of Wisconsin, how does the physician get into the picture?

A. When a workman has, or thinks he has, an injury or disease resulting from his employment, a report from the employer or a claim by the workman is filed with the Workmen's Compensation Division. To establish this claim a medical report verifying and specifiying the workman's injuries or diseases and the degree of disability is necessary. The Workmen's Compensation office and the employer or insurance company use the doctor's disability report to help determine the amount of compensation. If it turns out that the employer is obligated to provide or pay for necessary medical attention, he is required to supply the injured employe with "such medical–surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial members, appliances . . . as may be reasonably required to cure and relieve from the effects of the injury."

Q. How does the Workmen's Compensation Division determine whether the claim is justified?

A. Three essential elements must be ascertained before an award can be made to an injured claimant.

NEW WORKMEN'S COMPENSATION RULES

Effective Jan. 1, 1969, a physician or any other employer except a farmer is subject to the Workmen's Compensation Act if (1) he usually employs three or more employes or (2) he pays wages of $500 or more in any calendar quarter subsequent to July 1, 1968, covering services within Wisconsin.

An employer subject to the Act must have Workmen's Compensation insurance coverage, which can be obtained from any insurance company authorized to do such business within Wisconsin.

Serious penalties exist for failure to have insurance coverage. First, such failure is a misdemeanor and subject to fine of from $10 to $100 for each day of such illegal operation.

Second, the employer is personally responsible if one of the employes is injured while he is subject to coverage and is uninsured. Negligence by the employe is not a defense, and it need not be shown that the injury was caused by negligence of the employer.

A physician paying such wages need only obtain an insurance policy for Workmen's Compensation to comply with the law. The state Workmen's Compensation office is automatically notified of the issuance of the policy.

They are an employer–employe relationship; the employer must be subject to the Act; and it must be proved that the injury or disease was suffered or acquired in the course of employment.

Q. Can any physician treat employes under the Workmen's Compensation Act?

A. Any licensed physician, as a general rule. The Workmen's Compensation Act requires the employer to maintain a "reasonable number" of competent and impartial physicians ready to undertake the treatment of his employes and to permit the employes to make a choice of their physicians from among them.

Prior to 1939 a great many companies had limited panels. However, during that year the State Medical Society of Wisconsin and the insurance companies selling workmen's compensation insurance in the state entered into a joint agreement to enlarge the panels through the voluntary cooperation of employers and the insurance companies. The object was to give the workmen of Wisconsin an opportunity to secure virtual free choice of physician.

This agreement has come to be called the "Open Panel System." Any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employes may have his name included on the panel, which is prepared for each county in the state. These panels are certified to the insurance companies and are distributed to each employer of three or more persons in the state. This system has been so successful that more than 80% of the workmen in Wisconsin now have a wide choice of physicians.

Q. How does a doctor get on the panel?

A. About every three years the State Medical Society of Wisconsin circulates each of its members. The doctor is asked if he wants to be listed on the panel. If he completes the form and returns it promptly, he will automatically be listed on the next panel. However, a physician may at any time request listing or removal. The panels will not be changed until the next printing, but inquiries directed to the office of the Society will be answered on the basis of the current participation of each member.

Q. Does the doctor take on any obligations if he applies for a listing on the panel?

A. Yes. He agrees to have consultation when this is requested by the insurance carrier. He also agrees to communicate with the insurance carrier on the matter of choice of the consultant so that the consultant might be mutually agreed upon. Some exceptions will occur to these agreements, but the exceptions should be limited only to emergencies.

Q. Are any other practitioners listed on the "Open Panel"?

A. No. The State Medical Society panel lists only members of the State Medical Society. If any panel distributed by an insurance carrier contains the names of any other persons, it is not a panel approved by the State Medical Society.

Panels are distributed by another group of unlimited licensees, but these are not part of the State Medical Society program.

Q. What happens in the event of dispute or complaint about the handling of certain cases?

A. Under the "Open Panel" agreement a "State Conference Committee" is set up. It includes two representatives of the insurance carriers and two representatives of the State Medical Society. The duties of this committee are to mediate, if possible, cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary, cases where insurance carriers are charged with having unreasonably interfered with what is properly in the discretion or control of the attending physician, and differences that may arise between the attending physician and the insurance carrier relative to remuneration; to review any situation in which it is claimed there is a violation of ethics; and to hear complaints relative to the competency of those serving on the panel and remove their names from it if an investigation shows that such complaints are justified. Cases involving medical ethics will be referred to the board of censors of the appropriate county medical society. Local committees may be designated to investigate and report back to the "State Conference Committee" with recommendations when it seems necessary. Mediation will be attempted only in cases in which the physician involved is on the listing provided by the State Medical Society.

Q. How is the physician paid for services rendered to an injured workman who is covered under the act?

A. Usually the employer or his Workmen's Compensation insurance company pays the physician. This is true where it is conceded that the injury was sustained on the job and that the treatment rendered was necessary because of such injury.

Where there is a dispute and it is found that the case is not covered by the Workmen's Compensation Act, the employer is still liable for treatment authorized by him. On the other hand, the employe–patient is liable for unauthorized treatment. The Workmen's Compensation Division determines what treatment is covered under the Workmen's Compensation Act.

Q. What about other situations?

A. Where the employer fails to furnish a panel, the injured employe has complete free choice. Then the Workmen's Compensation Division has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible.

Sometimes the employe does not give notice of his injury or the necessity for treatment, or he refuses to accept the panel physician. In that event the employer or insurance company may not be liable.

Q. Are the claim reports filed by the physician kept confidential?

A. As a general rule communications from a patient to an attending physician are privileged. The Workmen's Compensation Act creates an exception to the law of privilege. The law provides that any physician attending a Workmen's Compensation claimant furnish to the employe, the employer, the Workmen's Compensation insurance carrier or the Workmen's Compensation Division information and reports relative to a compensation claim. The Division explains that it is a practical necessity for physicians to furnish information. Physicians will not be required to disclose confidential communications transmitted to them unless such information is necessary to a proper disposition of the claim. The physician's testimony should be absolutely fair, factual and unbiased.

Q. Does this mean that the physician need not divulge any information to the employer about an employe who files a claim?

A. The physician most certainly is not required to disclose information communicated to him by the employe when it goes beyond the information required for a proper disposition of a claim. However, under the Workmen's Compensation Act, the employer, the insurance company, or the Workmen's Compensation Division has the right to request a complete report on an injured employe. So, as a matter of fact, the physician may legally transmit to the employer such information as is required for a proper disposition of the claim. He is not privileged to release any other informaton than that ordinarily required for the handling of the claim.

Q. What is the doctor's role in disputed cases?

A. Naturally, there will sometimes be disputes between the employe and the employer or his compensation carrier as to whether the workman has suffered an injury in the course of his employment for which he is entitled to compensation. The physician may be asked to act as an expert witness for either the injured workman, the employer, or his insurance company. Therefore, doctors must be interested in whether the injury or disease was suffered in the course of employment and arose out of the employment.

When the employer or his insurance company agrees to the fact that the injury or disease was due to the employment, the question then is confined to the extent of liability on the part of the employer. In many instances this means the physician must be prepared to explain the disability in terms of its effect on the employe.

Q. What about "outside" physicians appearing as expert witnesses?

A. Sometimes the injured workman calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such cases the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully. The Workmen's Compensation Division is authorized in the interest of a fair and impartial hearing to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians are witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Q. How much is paid as a witness fee when physicians testify?

A. Ordinary witness fees are paid unless the physician performs work in preparation at the request of one of the parties to the dispute. In those cases in which the physician appears as an expert witness for the injured employe, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Workmen's Compensation Division will endeavor to protect the employe through permitting only what it considers to be a reasonable allowance for the expert witness. Each bill necessarily depends on the circumstances of the individual case. The State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness. With an itemized statement before it, the Division is in a better position to judge the work involved and the reasonableness of the charges of the physician.

Physicians must also keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employe for payment. Likewise, where a physician treats an injured employe, and such treatment has not been authorized by the employer, and the Division finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Q. Must a physician obey a subpoena when only ordinary witness fees are paid?

A. Yes. Some physicians believe that they cannot be required to obey a subpoena unless an expert witness fee is paid to them. This is erroneous. Wisconsin courts have held that, except where there is a demand for preparation, every witness, expert or otherwise, must obey a subpoena upon payment of the ordinary witness fee.

Q. Are there special procedures for the handling of compensation claims of state employes?

A. In a sense, yes. The Division is particularly explicit in its demands for itemized medical state-

ments and for verification of the reasonableness of the medical charges in the case of state employes who file compensation claims.

Such cases require a report (on a form supplied by the Division) from the attending physician, showing the nature of injury and the extent of disability. In addition, the physician and/or hospital must provide an itemized bill showing services rendered and charges made.

In any case in which disability results or medical expense is involved, a statement is required from the employe (on a form supplied by the Division) to the effect that he was injured in the course of his employment, reciting time and place of injury, the reasons for its occurrence, and the nature of injury, and stating all expenditures incurred for medical, surgical, and hospital treatment and medicines to the time of the claim, whether the claim is made for disability and, if so, what period of temporary disability and what permanent disability is claimed, and what salary has been paid by the state during the period of disability. If bills have been paid by the injured, receipts are to be attached.

Further, these cases require a statement from the employing department stating whether injury occurred in the course of employment and whether treatment is believed necessary as claimed. This will be made in conjunction with the employe's statement and on the same form. If the department is unable to make a statement, the reason is to be stated.

Q. Can you explain non-schedule injuries?

A. Non-schedule injuries are those to some portion of the body other than the legs, arms, ears, or eyes, or their constituent parts. In other words, non-schedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

Permanent disability for such injuries is estimated on the basis of the comparison between the nature of *the injury* and the nature of *an injury* causing permanent total disability of the entire body as a working unit.

Q. Now what is meant by schedule injuries?

A. Schedule injuries are estimated upon a different basis which bears no relation to wage loss. In these cases *the comparison is between the injured limb and a normal limb,* having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes, and ears, as well as any constituent part of these members and organs. Disability is measured as a percentage loss of use as compared to amputation at a designated joint or joints or, in the case of the eye or ear, as a percentage loss of use compared to total loss of sight or hearing.

The estimate of disability has no reference to any particular occupational use to which the member is to be put. For example, the violin player who has lost a digit vital for the purpose of playing may consequently lose a great deal in wages. However, he receives exactly the same number of weeks compensation as does the laborer who may be able to perform his work nearly as efficiently as before even with the loss of a digit.

The law fixes the value of each finger, thumb, toe, hand, arm, foot, and leg at various joints. In the estimation of disability the physician takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists. If disability is between joints, he considers the percentage of loss of function at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the injured arm with a normal arm at the elbow or, put conversely, with an arm which has been amputated at the elbow.

In every case of schedule injury where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases. Therefore, the estimate in such cases should be uniform. If the employe has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted. In case of schedule injuries the Workmen's Compensation Division has adopted a guide table for disability due to losses of motion.

Q. Is there anything to help the physician in rating disabilities?

A. Yes. The Department of Industry, Labor, and Human Relations worked closely with the State Medical Society and physicians in establishing a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In this guide, for example, where the loss of the function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20% of the arm at the shoulder.*

Elements of disability include amputations, limitation of motion, pain, weakness, lack of endurance, and deformity. The disability is the percentage loss of use as compared to amputation at the affected joint or joints. When amputation is between joints, the loss is 100 per cent at the amputated joint, plus the percentage of bone loss at the next phalanx as determined by comparative x-rays. This is the loss for amputation and additional disability rating may be due for additional disability factors of the remaining portion of the limb. The Division can determine the percentage of disability because of loss of motion from its guides, but the physician's opinion must be given as to the percentage of loss at each joint or joints that are affected for other elements of disability.

Physicians should submit their reports promptly. Delay may mean withholding of compensation to the injured employe and of professional fees to the physician.

In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. If, for example, in addition to limitation of motion, there is disabling pain and/or weakness, a percentage must be added for these elements. The physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability. It should be clearly indicated at what joint or joints the disability is measured.

Q. What if the physician disagrees with these methods of estimating disability?

A. Most parties are in general agreement as to the essential justice of the current provisions. Obviously, the physician's methods of estimating must be in accordance with the law regardless of his personal feelings as to the correctness or justness of the law. Any feelings that the law is harsh, inadequate, or inequitable in certain individual cases should never be allowed to influence the physician either in treating or in estimating disability.

Q. Should the doctor suggest the basis for settlement?

A. No. The physician who estimates disability should never concern himself with the result in number of weeks or in dollars. He should confine himself strictly to the medical field in estimating the disability on a functional basis. It is the function of the employer and the carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. Obviously, the physician should not be influenced by the amount of compensation which may be paid to the injured.

Q. Does the physician have any part in the computation of compensation?

A. Physicians should not attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than a particular physician might consider to be equitable. Computation of compensation based on estimates of disability is a function of the Workmen's Compensation Division. The attempts of physicians to compute sometimes result in erroneous figures and cause confusion and misunderstanding, both on the part of the physician and the injured person.

Q. In estimating disabilities in the schedule group, would 50% loss of motion mean 50% loss of function of the limb?

A. No, not necessarily. Loss of use and loss of motion are not identical. All functions of the limb, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, and so forth, must be considered. The physician must assign to each factor the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member. Also, to each factor must be applied the percentage of loss of motion of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

When disability consists of loss of motion of a finger, the physician need not convert the degrees or percentage loss of flexion or extension into loss of use as shown by the guide on page 25, since the Division can do this from the information supplied. The physician should clearly set forth the degrees or percentage loss of flexion and/or loss of extension at each joint of each finger that is affected. Normal extension is in a position of 180 degrees at all joints. Normal flexion at the distal joint of the finger is taken to be 70 degrees in the absence of any indication to the contrary. At the second or middle joint, normal flexion is considered to be 100 degrees and at the proximal 90 degrees. For example, a 30-degree loss of extension at the middle joint is 30% loss of extension rather than 16%, which many physicians often indicate. This is true because 30% loss of extension must be a percentage of the total motion of the joint, in this case the middle joint, which has only 100 degrees of motion.

Q. What kind of forms are used in reporting disabilities under the Compensation Act?

A. The Division has adopted special forms for use of physicians. If the Division is to pass upon a disability, it is necessary that the physician's report contain all of the information requested on this form as a basic minimum. If for some reason the form is not used by the physician, he should make certain that the requirements of the form are met. This will save returning the form to the physician with a request for supplementary report.

Q. If the physician completes the form properly, does this eliminate the need for him to personally appear in cases before the Division?

A. Over 90% of all injury claims are paid by the employer or insurance company without

Guide for Estimating Permanent Disabilities Under Workmen's Compensation

The following guide represents percentages of loss of use for losses of motion as compared with amputations at the involved joints.

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90°, but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Total ankylosis of arm at elbow at right angles	
With radio-ulnar motion intact	50%
With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle, and proximal joints	100%	100%

Fingers

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10%	= 1%	10%	= 2%
	20%	= 2%	20%	= 4%
	30%	= 3%	30%	= 6%
	40%	= 5%	40%	= 8%
	50%	= 10%	50%	= 15%
	60%	= 15%	60%	= 20%
	70%	= 20%	70%	= 30%
	80%	= 25%	80%	= 40%
			100%	= 60%
Middle joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 10%
	40%	= 25%	40%	= 15%
	50%	= 40%	50%	= 30%
	60%	= 50%	60%	= 50%
	70%	= 60%	70%	= 70%
	80%	= 70%	80%	= 90%
			100%	= 100%
Proximal joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 15%
	40%	= 20%	40%	= 20%
	50%	= 25%	50%	= 25%
	60%	= 30%	60%	= 40%
	70%	= 35%	70%	= 75%
	80%	= 40%	80%	= 85%
			90%	= 100%

Thumb

Distal joint same as for fingers.

Proximal joint 40% of the loss of use indicated for fingers.

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis — favorable position 10°–15° equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

dispute and on the basis of reports submitted. Where dispute arises and formal hearing becomes necessary, the Division has a type of physician's report form which may eliminate the necessity of having the physician appear personally. The law provides that the contents of certified or verified medical and surgical reports by physicians licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima-facie evidence as to the matter contained therein, subject to such rules and such limitations as may be prescribed. Likewise, reports of physicians and surgeons, wherever licensed and practicing, to whom the claimant has been sent for examination and treatment by the employer or insurer, are available for evidence provided the doctor consents to subject himself to cross-examination. The use of the form mentioned above makes it unnecessary for the physician to appear personally in some cases, especially where the issue and dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of the hearing.

Q. Are special forms used in cases of loss of vision?

A. Yes. These forms will be supplied to physicians upon their request, along with rules for determining loss of visual efficiency caused by industrial injury.

Q. Are there any special forms for estimating loss of hearing?

A. In cooperation with the medical profession, insurance carriers, industry, and labor, the Division has worked out formulas for determining the loss of hearing suffered during the course and as a result of particular employments. These formulas are a guide at the present time and are primarily for the assistance of the examining physician. Copies of the formulas and associated material may be obtained by writing the Workmen's Compensation office.

Q. Are there any suggestions for completing the forms required?

A. A full report covering all factors is necessary to be able to fix the percentage of disability. Therefore, the doctor should set out in detail the elements which constitute disability. He should state as nearly as possible the weight and percentage of loss which has been ascribed to each. He should also set out his opinion as to the ultimate total percentage of disability which has resulted. This enables the Division to check the report with its standards and to arrive at an intelligent and uniform conclusion.

Q. What about terminology?

A. Many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second, and proximal joints. Some physicians refer to the first, second, third, and fourth fingers, and some designate the thumb as the first finger. Some physicians speak of the interphalangeal joints, and sometimes of the first, second, and third joints, leaving confusion as to the point of measurement. The law designates distal, second, and proximal joints. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reports can be avoided.

Q. Can a physician use his own standard for measurement of disability?

A. Only those adopted and published by the Department of Industry, Labor, and Human Relations itself should be considered as authoritative or as representing the Department's thought as to percentages of disability based on certain functional losses. Obviously, physicians will have various ideas as to standards and schedules for estimating disability. However, they should use these as a matter of interest. Their opinions should be based upon their own examination and analysis and by reference to the standards which the Department has adopted.

Q. To whom should the physician furnish reports with regard to a compensation claim?

A. Regardless of any other statutory provisions, the law specifically provides that any physician attending a Workmen's Compensation claimant may furnish to the employe, employer, Workmen's Compensation insurance carrier, or the Division information and reports relative to a compensation claim. It further provides that a physician from outside Wisconsin may testify in compensation proceedings if he is licensed for the place of his residence or practice.

Q. How does a physician get the needed report forms?

A. Simply write to the Workmen's Compensation Division, Hill Farm State Office Building, Box 2209, Madison, Wis. 53701.

Q. Where can the physician go for additional help in handling compensation cases?

A. The Workmen's Compensation Act and its administration is necessarily highly technical. The panel physician will find it easier to deal with the employer, the insurance carrier, and the patient if he has a reasonable understanding of its operation.

Both the office of the State Medical Society and the Workmen's Compensation Division stand ready to assist in solving some of the problems facing the physician who treats patients entitled to or claiming benefits under the act. Inquiries may be directed either to the State Medical Society, Box 1109, Madison, Wis. 53701, or to Ralph E. Gintz, Administrator of Workmen's Compensation, Hill Farm State Office Building, 4802 Sheboygan Avenue, Box 2209, Madison, Wis. 53701.

MEDICOLEGAL FORMS WITH LEGAL ANALYSIS—AMA

The Law Department of the American Medical Association has published a booklet entitled, "Medicolegal Forms with Legal Analysis," which is available upon request to the AMA, 535 North Dearborn Street, Chicago, Ill. 60610. Subjects include: Physician–Patient Relationship, Discharge of Physician, Substitute Physician, Confidential Relationship, Patient's Right to Privacy, Liability for Unauthorized Treatment, Consent to Treatment, Informed Consent, Extension of Operation, Limitations on Treatment, Treatment of Minors, Treatment of Incompetents, Warranties as to Results of Treatment, Sterilization, Implied and Oral Consent, Written Consent to Treatment, Artificial Insemination, and Autopsies.

NARCOTICS

Annual Registration

You must register with and pay tax to the District Director for the Internal Revenue District in which you propose to engage in any activity involving the use of narcotic drugs. For Wisconsin, the correct address is District Director, Internal Revenue Service, Post Office Building, Room 296, Milwaukee, Wisconsin 53202.

Change of Residence

Do not fail to notify the District Director, Milwaukee, Wisconsin, of any change of address. Failure to notify him within 30 days will make you subject to the tax, penalty and interest.

In Case of Death

The Regional Director, Federal Bureau of Narcotics and Dangerous Drugs, Minneapolis, Minnesota, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a recent communication to the State Medical Society:

> "The deceased physician's Special Tax Stamp, unused Government order forms, and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused Government order forms (Form 2513) should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin 53202. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Director, Bureau of Narcotics and Dangerous Drugs, 402 Federal Building, 110 South Fourth Street, Minneapolis, Minnesota 55401, after the drugs have been inventoried on Forms 142, which can be obtained from the Regional Director. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to the Bureau of Narcotics and Dangerous Drugs."

Preprinted Prescription Blanks

The Treasury Department, Federal Bureau of Narcotics and Dangerous Drugs, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

Ethical Practices in Reference to Workmen's Compensation and the "Open Panel Program"

(PREPARED BY CONFERENCE COMMITTEE ON OPEN PANELS)

THE State Medical Society and the Workmen's Compensation insurance carriers have for many years subscribed to the principles of the Open Panel, wherein any member of the State Medical Society who so expresses a desire may have his name, office address, and office telephone listed on panels prepared on a county basis and distributed to employers covered by the Workmen's Compensation Act.

Being listed carries certain obligations upon the physician and the insurance carrier. The industrial nurse also has obligations and ethics which must guide her in her handling of the case.

To clarify certain points of possible misunderstanding, the Conference Committee on Open Panels is listing below certain principles which should be followed by all parties concerned with the medical aspects of the compensation program.

* * *

Consultation

It is a basic principle of the Open Panel Program that consultation can be requested by either the attending physician, the insurance carrier, the employer, or the employee. It is essential that the request for consultation be known to the other parties immediately concerned. Also, the selection of the consultant should be **mutually acceptable to both the attending physician, and the insurance carrier or the employer.**

If the Attending Physician Seeks Consultation: The insurance carrier should be notified of such a request, and if the consultant requested is not acceptable to the insurance carrier, another consultant acceptable to both parties should be selected. Under no circumstances should the attending physician arrange consultation without proper notification and authorization unless an emergency exists.

If the Insurance Carrier Seeks Consultation: Proper notification should be given the attending physician, and preferably he should be given the names of alternate consultants from which he can select one agreeable to him. Under no circumstances is it ethical for the insurance carrier (or the employer) to call in a consultant until agreement is made with the attending physician. If the attending physician refuses consultation, it is proper for the insurance carrier to place the matter in the form of a grievance before the Conference Committee on Open Panels; and if cooperation is still denied, the physician refusing consultation can be removed from the panel.

Frequency of Consultation: If the attending physician requests consultation, it can be as frequent as the insurance carrier deems reasonable. If the insurance carrier requests consultation, it can be as frequent as desired, and the insurance carrier is responsible for the reasonable expense of such consultation.

Filing of Consultation Reports: Under any circumstances the consultant is duty bound to file identical reports with both the attending physician and the insurance carrier of the employer.

Consultation Does Not Mean "Taking Over The Case": A consultant is not to take over the care of the case, except by mutual understanding and agreement. The case remains that of the attending physician until discharged by him, unless voluntarily released to the consultant. A written release is recommended. See page 66 of the *Wisconsin Medical Journal*, January 1954, for recommended release form.

Reports

The filing of reports is a direct responsibility of any physician participating in the Workmen's Compensation Program. As a means of lessening the extent of paper work involved in required reporting the Conference Committee on Open Panels has devised simplified report forms for the initial report, the progress report, and the final report. The majority of insurance carriers subscribing to the Open Panel are using these forms. If physicians are requested to fill out complicated report forms, the Conference Committee will try to have the insurance company requesting such information adopt the simplified forms.

The Department of Industry, Labor, and Human Relations (formerly the Industrial Commission) WC–16 Report: This report form is to be completed by the physician participating in the compensation program when disability exceeds three weeks, or any permanent disability results

from the injury. The report form may be obtained from the insurance carrier or the Department of Industry, Labor and Human Relations, which uses the information thereon to determine the amount of compensation payable to the injured worker. Failure to supply the report promptly may mean that compensation will be withheld by the employer or insurance carrier, with injustice to the patient. It has been stated that compensation delayed may be as serious as compensation denied. The report form is filed with the employer or insurance carrier and transmitted by it to the Workmen's Compensation Division.

Payment for Reports: Occasionally physicians have suggested the advisability of being reimbursed for the preparation of reports for insurance companies and the Department. It is the opinion of the Conference Committee on Open Panels that the following principles be applied:

Simplified Reports (First Report, Progress Report, Final Reports): No charge.

WC–16 Report to the Department of I.L., and H.R.: No charge.

If special reports are requested, or the insurance carrier does not wish to use the recommended simplified reports and requires a rather extraordinary report, a separate charge (depending on the extent of the report) is proper.

Complaints

The Conference Committee on Open Panels was established to iron out any difficulties between participating physicians and insurance carriers in all matters concerning charges, alleged unethical practices, etc. However, the Conference Committee will not accept a case until efforts have been made, through local personal contact, to reach a satisfactory solution of the problem involved.

Free Choice of Physician

It is improper for an industrial nurse, or any person responsible to management, to direct an injured employee to a specific physician for care. If the injured patient asks for recommendations, a list of at least three physicians should be given, and the choice should be left entirely to the patient. When the Open Panel is used, every effort should be made to retain the relationship between injured worker and his family physician. If his injury is of a specialized nature which suggests need for consultation, such arrangements can be made as suggested above. If the injury involves the eye and a selection of physicians restricting their practice to this field is available, such information should be given the patient by referring him to the panel listing under the heading of "Eye, Ear, Nose and Throat." The industrial nurse must do her utmost to retain the good will of all physicians whose patients are employed in the plant. To do this she must bend every effort to maintain the philosophy of "free choice" of medical care for the injured employee.

Changing Physicians

The Compensation Act provides not only that the employee shall have the right to make choice of an attending physician from a panel but that he shall, if he wishes, have the right to make a second choice of physician from the panel upon request. If that is done there should be no hesitancy on the part of the first physician chosen to relinquish the right to treat, but also there should be full cooperation with the second physician chosen in order to afford him full access to history and treatment already rendered, so that the second physician chosen under the statutory requirement may not be embarrassed as to his treatment of the employee. The law further provides that upon summary hearing the Department may permit an employee to select a physician not on the panel.

Although these provisions are rarely invoked, they are implicit in the Compensation Act and should be fully recognized and followed when request is made by an employee.

CAN YOU PRACTICE WITHOUT A LICENSE?

The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service or moving to Wisconsin from another state *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to criticism or disciplinary action.

Temporary licenses may be granted under special circumstances by the State Board of Medical Examiners. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

Reference: Sections 147.14(1), 147.15(2), 147.19, Wisconsin Statutes, 1967.

The Abused Child Law

How It Affects You

Abuse of children by parents and others can be found at all economic, educational and social levels. The cumulative effect of repeated beatings or other forms of severe abuse, which may include physical crippling, brain damage or even death, must be prevented.

The 1965 Legislature strengthened the prior law making reporting of suspected cases of child abuse mandatory, and adding to physicians and surgeons as the persons who are required to report, nurses, social workers and school administrators. The 1967 Legislature added dentists and hospital administrators to those persons required to report. The Legislature further provided that the reports could be made to the city police departments in lieu of the sheriff and granted civil as well as the criminal immunity from suit where a report is made in good faith.

The actions of the Legislature have immeasurably increased the probabilities that perpetrators of abuse will be identified and will receive rehabilitative help while the abused child will be extended protection from further abuse.

The Law

The law, quoted in full from the Wisconsin Statutes is as follows:

48.981 Reports On Abused Or Injured Children. (1) A physician or surgeon being of the opinion as specified in s. 885.21 (1) (1), or a nurse, hospital administrator, dentist, social worker or school administrator having reasonable cause to believe that a child brought to him or coming before him has had physical injury or other abuse inflicted upon him by another, other than by accidental means, shall orally report the same and the facts and circumstances forming the opinion. The report shall be made immediately by telephone or otherwise, and followed by a report in writing to a county child welfare agency specified in s. 48.56 (1), the sheriff of the county or the city police department. The recipient of the report shall notify the other receivers of reports within 48 hours. When the recipient of the report is the sheriff of the county or city police department, he shall make an investigation consistent with the facts and circumstances described in the report and take whatever emergency action is necessary for the protection of the child. If the sheriff or city police department determines that legal action is necessary he shall refer the case to the district attorney for criminal prosecution. The county child welfare agency specified in s. 48.56 (1) shall investigate each report and act in accordance with its powers and duties as set forth in s. 48.57.

(2) Anyone, in good faith, participating in the making of a report pursuant to this section or participating in a judicial proceeding resulting therefrom shall in so doing be immune from any liability, civil or criminal, that might otherwise be incurred or imposed.

(3) Anyone knowingly and wilfully violating this section by failing to file a report as required, may be fined not more than $100 or imprisoned not more than 6 months or both.

Your Responsibility

Physicians and surgeons, nurses, hospital administrators, dentists, social workers and school administrators may make their initial reports in any expeditious manner to the county welfare department, the county sheriff or the city police department. However, follow up reports must be in writing to the agency first contacted.

There are no legal requirements for the form of the written report. It may be a letter stating salient points of the individual case, or it may be merely a note or cover letter that accompanies copies of the medical findings and case history. Where x-rays reinforce the initial diagnosis of the battered child, physicians and surgeons and dentists should incorporate such findings in their reports. It is recommended by the Department of Health and Social Services that the report also contain:

1. The names and addresses of the child and his parents or whoever is caring for him;
2. The child's age;
3. The nature of the child's condition, including any evidence of previous injuries or disabilities;
4. Any other information that may be helpful in establishing the reason for the abuse and the identity of the perpetrator(s).

If additional information is needed concerning reporting the Department of Health and Social Services suggests that you contact your local welfare department.

Governmental Responsibility

The Department of Health and Social Services furnished the following information.

The first responsibility of the county welfare department (or county children's board) is to see that the child is safe while a complete investigation is made. If the child is not hospitalized the question of whether he should be removed from his home, even temporarily, must be dealt with. In some cases such action may not be necessary; in others, arrangements will have to be made by the county welfare department to place the child in the temporary care of relatives or friends or in an emergency foster home.

Having received a report of an abused child the social worker may need to talk to the person making the report to aid in evaluating the child's parents or his home. The worker will meet with the parents, and will probably interview relatives, neighbors, law enforcement officers and others who may have

information that will help determine the true cause and nature of the child abuse.

The main concern will be to find out whether abuse is likely to be repeated if the child is returned to the home. The next step will be to develop a counseling plan aimed at stabilizing the family to prevent further abuse.

If removal of the child is necessary the county welfare department will petition the juvenile court for custody and will then place the child in a foster home or suitable child care institution. Meanwhile, the county welfare department will help the parents prepare for the time when their child may be safely returned to them.

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Sections 52.36 and 885.23, Wisconsin Statutes, 1967.

Consents for Treatment of a Minor

A minor is defined by the Wisconsin Statutes as a person who is under 21. Consents to treatment are necessary for minors as well as for those over 21. Consents may be oral as well as written, but unless a physician can produce disinterested witnesses with good memories, he will do better to have the consent in writing.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless such relative has been appointed as such minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an *emergency*, a consent is *not* necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law *implies* the consent of the patient, or in the case of a minor, of his parent or guardian. BECAUSE THE LAW DOES NOT IMPLY CONSENT BEYOND THE TREATMENT ACTUALLY NECESSARY TO MEET AN EMERGENCY, THE PHYSICIAN MAY SAFELY TREAT ONLY THE EMERGENCY CONDITION ITSELF, AND NOTHING ELSE, WITHOUT ACTUAL CONSENT OF A PARENT OR GUARDIAN.

Second, an *emancipated* minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

Note: On the subject of consents generally, see 1958 *Blue Book* issue of this JOURNAL, Vol. 57, issue 1, pages 4–58.

Are You Risking an Abandonment Charge?

The doctor shortage and the mechanization of medicine are increasing the risks, says this attorney, who describes the dangers of telephone diagnosis and other traps

By NEIL L. CHAYET, Esq., Boston, Massachusetts

IT'S FAIRLY COMMON practice for a busy doctor to postpone seeing a patient. But it can also be a dangerous practice. For if the doctor's patient load is so heavy that he must neglect some of his patients—and a patient's condition worsens as a result of that neglect—he may be open to a charge of abandonment.

Abandonment suits still aren't everyday affairs, but they show signs of increasing. The probable reasons aren't far to seek: (1) the shortage of doctors, tempting physicians to take on more patients than they can handle; (2) "the mechanization of medicine"—meaning the increasingly impersonal doctor-patient relationship resulting from specialization and the related movement of medicine toward team care in highly mechanized hospitals.

On the whole, patients haven't realized how much the nature of medical practice has changed. They still expect their doctor to come running at the ring of a telephone. If he won't and hasn't warned them that he won't make house calls they may well feel abandoned—and make their next phone call to a lawyer.

Just what is the medicolegal meaning of abandonment? Laws vary from state to state and interpretations from court to court, but in general it means a physician's termination of a doctor-patient relationship without the patient's consent and without giving him adequate notice and opportunity to find another physician. Such a relationship is established when a doctor accepts a person as a patient. But in law, even simple-sounding words usually aren't as simple as they sound. Many abandonment cases have hinged on whether the doctor had indeed "accepted" the person as a patient and if so under what conditions or limitations. For some legal interpretations of the terms "doctor-patient relationship" and "accept" and "terminate," let's take a look at some specific situations and cases:

When a stranger phones you for emergency treatment. "I've got these terrible stomach pains," he tells you. "Could you come right away?" No statute compels you to accept any would-be patient, and you're on safe legal ground if you refer him to another physician or to the nearest emergency room. But there's one condition: Don't attempt to diagnose his illness or recommend treatment. If you do, a court may rule that you thereby accepted the stranger as a patient and so assumed the responsibility for his treatment.

New York had a case in point not long ago. A man awoke with severe chest pains and walked to the emergency room of a hospital three blocks away. He mentioned that he was a member of a group health plan. The nurse told him the hospital had no connection with the plan and put him in touch with one of the plan's doctors. Over the phone, the man described his pains and medical history to the doctor, who allegedly told him to return home and see his regular physician in the morning. The sick man obediently went home—and died. A suit against the doctor and the hospital was dismissed, but an appellate court ordered a new trial. Had the suit not been dismissed, the court ruled, a jury could have concluded that the doctor "undertook to diagnose the ailments of the deceased" and that the jurors thereupon "could have decided whether he had abandoned the patient." Eventually both doctor and hospital agreed to a settlement.

When a former patient demands to see you immediately. Is there a doctor-patient relationship when a patient whom you treated for a broken leg five years ago and haven't seen since asks to see you at once? The essential question here is whether the original relationship was terminated. This in turn depends on the nature of the illness. In the case of a broken leg, a court would probably hold that termination had occurred after complete recovery or, more specifically, one year after the doctor's final checkup and the payment of the bill. Thus you would have as much right to refuse to see this former patient as you would have to turn away a stranger.

When you want to terminate a relationship. In the case of a disease such as cancer, where the cure may not be final, either doctor or patient would have to end the relationship formally, usually with a letter of termination. Such a letter from a doctor should always advise the patient whether he needs further treatment and allow him enough time to arrange for it. Not long ago, the Florida Su-

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preme Court upheld a $65,000 verdict against a doctor who had discharged a patient suffering from a cancer that later enveloped his entire lower lip and chin. The doctor had neither recommended nor arranged for further treatment.

Formal termination isn't necessary with most of your patients; as in the case of the broken leg, termination is implied by the conclusion of the illness. Be sure, however, to terminate your relationship *officially* with patients who won't pay their bills. When a patient doesn't pay, it usually means he doesn't have the money or is dissatisfied with you. Either situation could motivate a suit. It has been argued that a letter of termination in itself may precipitate a law suit. It may—but it's riskier to do nothing and thereby invite an eventual charge of abandonment.

When a regular patient demands priority. Suppose a patient comes into your office and asks to see you at once, ahead of others waiting for you. You're on safe legal ground if you refuse to treat him ahead of other patients—unless he's come to consult you because of a genuine emergency. It's a physician's right to regulate his practice as he sees fit.

The question of what constitutes an emergency is also left to the doctor's medical judgment. But your judgment may have to survive a court test. Recently a Tennessee doctor and his nurse had to pay $25,000 for failing to respond in an emergency, even though it wasn't proved that their failure caused the patient's death. The mother of a 22-month-old boy, who was being treated for a tonsil and throat infection, had brought him to the doctor's office when his condition worsened. The nurse notified the doctor, who was at lunch, and then went to lunch herself. While both were out of the office, the child died after profuse vomiting.

When the mother sued both doctor and nurse for abandonment, the doctor and his expert witnesses testified that the child had died of a sudden viral infection. An appeals court affirmed that the jury could disregard such testimony and find that the child might have died of aspiration of its own vomit. In such a case, the court held, the child might not have died if he had received immediate treatment from either doctor or nurse. As this case makes clear, a doctor's momentary neglect may be enough to constitute abandonment.

When absence makes you unavailable to the patient. The key concept here is not the fact of leaving the patient, but leaving him without providing for his care in your absence. A few years ago, the Supreme Court of Oregon affirmed a judgment against a doctor who had neglected to make such provision. The suit was brought against him by a woman whom he had treated for a broken arm. Up to the day the doctor left for a vacation in Mexico, the woman complained that the cast on her arm was too tight, but he thought it unnecessary to split the cast or remove it. Nor did he entrust her to another doctor in his absence. When he returned and removed the cast, plaster and gauze were found imbedded in the flesh inside the elbow joint, according to one woman's testimony. Permanently crippled, the patient was awarded damages of $17,500.

The doctor planning a vacation or other trip must give his ailing patients enough advance notice of his impending absence to let them arrange for other medical help. How much notice depends on the illness. Two days would probably be enough for a patient with a broken arm, while 30 days might be in order for a patient requiring specialized treatment. Advance notice was at issue recently in Maine, where a doctor was granted a new trial after a jury verdict against him. Although the doctor had arranged for a competent substitute, he had failed to tell one of his pregnant patients that he was going on a two-day fishing trip.

During his absence, the woman's baby was delivered by the substitute. Later the woman sued her doctor charging that (1) she had suffered needlessly because the substitute failed to administer the anesthetic she wanted and (2) she had been denied the choice of another physician because her doctor hadn't warned her that he would be unavailable. The state Supreme Court took away her jury award on the ground that she had failed to prove she would have suffered less if her own doctor had been present. However the court confirmed the right of such a patient to receive plenty of advance notice concerning the need for a possible substitute obstetrician.

When a substitute physician errs. Are you responsible for your substitute's errors or derelections? Only if your patient can prove that you failed to exercise "due care" in choosing the substitute. A substitute may also be held liable for abandonment. That happened to a doctor who agreed with the surgeon, reversing a lower court decision and ordering a new trial. The suit was finally settled out of court.

The cases mentioned so far show patients seeking judgments for physical harm. But they may also try to collect damages for mental anguish. Unless accompanied by physical injury, however, mental anguish (as distinguished from mental illness) isn't usually actionable. Some courts, however, have ruled otherwise.[1]

In one such instance, a man was "abandoned" while receiving X-ray therapy for a cancerous growth on his cheek. He had been placed on a table with sandbags on both sides of his head and the X-ray machine trained on his cheek. Then the doctor and technician apparently forgot about him—after also neglecting to tell him that the machine would shut itself off automatically. The man lay there for three and a half hours, afraid to move, afraid not to move. Finally he fell off the table. He wasn't hurt physically, but the court allowed him to recover for his hours of mental anguish.

The cases cited show that a potential for a charge of abandonment exists in many common

situations. Happily, that potential is rarely realized. The physician can protect himself further with these four basic safeguards:

1. If you must turn away a patient, do so on medical grounds. It's acceptable to refuse a patient immediate attention if you feel others have more urgent need of your services. It's not acceptable to neglect him merely because you have too many patients.

2. When you accept a patient, state plainly whatever limitations you intend to put upon your services.

3. If you want to drop a patient or if a patient is dissatisfied and abandons *you*, be sure to send him a letter of termination. Keep all such correspondence as part of your records.[2]

4. Whenever you're going to be unavailable, notify patients who are acutely ill, pregnant, convalescing, or suffering from chronic disorders. Give those patients the name, address and phone number of a substitute physician.[3]

EDITOR'S NOTES:

1. After earlier hesitating about compensating for emotional harm suffered without attendant physical injury, the Wisconsin Supreme Court again considered this question in 1963. It held in *Alsteen v. Gehl*, 21 Wis. (2d) 349, at page 358 that the correct statement of the standard for legal liability is as follows:

> "One who by extreme and outrageous conduct intentionally causes severe emotional distress to another is subject to liability for such emotional distress and for bodily harm resulting from it."

2. The Society attorneys advise that after a physician gives notice that he wishes to withdraw from a case he should remain and perform necessary services until a successor physician acceptable to the patient takes over. Otherwise the first physician runs the legal risk of an abandonment charge, even though he gave written notice of his intention to withdraw.

3. An additional source of potential legal liability is the premature discharge of a patient. The legal principle has been well phrased as follows in a recent text:

> "Premature discharge of the patient may also result in a charge of abandonment if it turns out that the patient required further care under the standards of good medical practice."

Quoted from *Doctor and Patient and the Law*, Stetler and Moritz, The C. V. Mosby Company, 1962, p. 324.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

Only licensed physicians and registered pharmacists may sell contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used. In no event may such article, drug or preparation be sold to any unmarried person.

Prohibited also is the advertising or public display of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Section 151.15, Wisconsin Statutes, 1967.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Board of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

Some birth certificates filed with the State Board of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes, 1967.

The Expert Witness

By BENJAMIN J. CANTOR, B.E.E., LL.B.

Beyond the basic qualifications of knowledge and experience necessary to be an expert in his field, an expert witness must also have the ability to communicate clearly and objectively his skilled interpretation of technical evidence. Mr. Cantor suggests thirty rules, ranging from manners to mannerisms, that will aid the expert witness in doing so, and thereby aid the judge and the jury in reaching a fair and proper conclusion from the testimony.

AN EXPERT WITNESS is one who has acquired by study, practice and extensive experience a special skill and superior knowledge in the art and science of a particular field about which persons who have no special training are incapable of forming an accurate opinion or of deducing correct conclusions. Whether a witness is qualified as an expert is a preliminary question of fact for the trial court to determine. This decision will not generally be overturned unless it can be shown that there was an abuse of discretion on the part of the presiding judge.

The expert witness differs from the ordinary witness in that the former can state his opinions or conclusions based on ultimate fact, whereas the latter can testify only to things that he saw, heard, tasted, smelled or felt. The weight that a jury will give to the testimony of an expert witness depends upon the extent of his learning, skill, experience and the reasons he gives for his opinions and conclusions.

The following factors are important in spelling out an expert witness's qualifications: education, experience, articles published, lectures delivered, membership in professional societies and organizations, awards and recognition as an expert by others in the same field. Because the expert witness' opinion often concerns one of the important elements of the case, *e.g.*, damages or liability, it is very important that he be well qualified and of high moral character and integrity. It must be remembered that the credence given by the court and the jury to the testimony of an expert witness depends principally on his qualifications, his ability to withstand severe cross-examination and his capability in expressing himself so that the judge and jury will understand his testimony.

Before an expert is put on the witness stand, the attorney should have a conference with him to determine his qualifications and also to seek his advice on the framing of questions. The attorney and the expert witness must have a meeting of the minds as to their objectives. In order to be most effective, the expertness of the witness and the legal astuteness of the lawyer should be aimed at the same objective.

As a witness, the expert should speak up so that the jury, judge, stenographer, opposing counsel and all other parties in the case can hear him. His testimony and explanations should be clear enough so that all of the jurors can understand and grasp them. Technical terms should be defined and put into simple language for effectiveness. In testifying from an exhibit, the witness should refer to the exhibit number or some other identification. When indicating or pointing to an object in the exhibit, he should describe what he is referring to so that the court stenographer can make an accurate and complete record of his testimony, which becomes very important when the transcript of the testimony is used in a hearing on a motion for a new trial or an appeal to a higher tribunal.

Enough time should be taken in answering questions so that the witness can gather his thoughts and give an accurate and brief answer. (It's like the fellow who apologized for writing a long letter and said that if he had had time it would have been shorter.) If the questions are answered quickly on direct examination, and then there is a tendency to slow up on cross-examination, the jury will notice this and feel that the witness is hedging or is in trouble. If the witness is asked to give an opinion and he feels that he hasn't enough facts or enough time to form an intelligent expert opinion, then he should so inform the court. A jury is impressed with such frankness on the part of a witness. The expert, not expected to rely entirely on his memory, should always have adequate notes in his possession when called as a witness so that he can testify as to all of the details. He should keep in mind that his role is to aid the court and the jury in understanding the technical evidence so that they can make a proper evaluation of the facts.

Some other suggestions which can be offered as an aid to being a good witness are:

1. Walk to the witness stand with even steps.
2. When taking the oath, hold your right arm up high with fingers straight and look at the officer administering the oath.

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3. When the officer finishes the oath, ". . . so help you God", you say "I do" in a loud voice so that all in the courtroom can hear. Do not act timid.

4. Think before you speak.

5. When one of the lawyers calls "Objection" or if the court interrupts, stop your answer immediately and wait until the court gives its ruling.

6. Be fair and frank. Don't be too anxious to please or too eager to fight.

7. If you make a mistake, or a slight contradiction, admit it and correct it. Don't tie yourself in knots trying to cover up some slip of speech or memory.

8. Keep your temper. Don't let anyone rile you into arguments over trivial points or even important ones. Be firm, but flexible.

9. If you can't answer "yes" or "no", say so. Modify your reply by "under certain circumstances . . .".

10. If you don't know or can't remember, say so. Those are legitimate answers to the most illegitimate questions.

11. Avoid mannerisms of speech. The habit of prefacing your replies with something like "I can truthfully say . . ." may cast unwarranted doubts on your whole testimony.

12. Don't get caught by snares like this: "Did you ever discuss this with anyone?" Of course you did, and if asked, name the people—the lawyer, the parties to the suit, etc.

13. If the lawyer asks you, "Are you as positive about this as the rest of your testimony?", STOP! Are you?

14. "Do you want this jury to understand . . . ?" Listen closely to that one. If you don't want the jury to understand it that way, make clear what you do want them to understand.

15. Never try to be a "smart" witness. If a lawyer is obviously giving you a chance for a wisecrack, avoid it like the plague. It's just the anesthetic before the knife—putting you in the "now-this-won't-hurt-a-bit" mood.

16. If the opposing attorney interrupts you before you have a chance to complete your answer, you should indicate this to the presiding judge.

17. Don't volunteer any information.

18. Express yourself well, using simple technical language that the jury, judge and attorneys can understand.

19. Be brief. Just answer the question and stop.

20. During the recess you should not carry on any conversation with other witnesses or parties to the controversy. You should stand aloof from everyone except the attorney who retains you to testify.

21. Don't chew gum.

22. Don't memorize any of your testimony.

23. Never nod your head to indicate "yes" or "no".

24. Speak up so that the judge, jury, counsel, stenographer and others can hear you.

25. Wait until the entire question is asked before answering.

26. On cross-examination, don't look at your attorney.

27. Keep your hands away from your mouth or face.

28. When addressing the court, use "Your Honor"; when addressing the attorneys, use their names.

29. At the conclusion of your testimony, ask if you may be excused; then leave the courtroom immediately.

30. Last, remember that the witness stand is not a comfortable place for one who is not telling "the truth, the whole truth and nothing but the truth".

An expert is entitled to a witness fee, the amount of which is subject to an arrangement between him and the attorney who calls him to testify. It is good practice to arrange for such a fee prior to testifying. If the expert is called on only to testify to facts of which he already has knowledge, he may be subpoenaed as a witness and paid the statutory fee, plus an allowance for travel. In this case he may refuse to give any "expert" opinion or testimony unless he is adequately compensated. An expert who is subpoenaed may not ordinarily be as cooperative and will not put as much effort into his testimony as one who has willingly agreed to appear as an expert witness. Thus, as a practical matter, the expert should be retained at a reasonable fee. If an expert must prepare himself before testifying by making certain tests or doing research, he is entitled to reasonable fees for that work. When an expert is called as a witness for the sole purpose of "proving" or verifying certain material, he is generally given a reasonable fee for his time.

It is wise, when called as a witness, to ask to be put "on call" so that there won't be time lost "hanging around" the courthouse. In any event, the witness shouldn't expect to be out of court in a hurry.

Some lawyers representing plaintiffs, especially in tort cases, will ask an expert to testify on a "contingent fee" basis—he won't be paid a witness fee if the plaintiff loses, but in the event that the plaintiff prevails, the expert will be paid. This puts the witness in the same position as the attorney who has a stake in the outcome of the case, and thus the witness gives up his proper role as a disinterested expert witness. Having a pecuniary interest in the case, the expert becomes an "interested" and biased party, and therefore his testimony will carry much less weight. It should be kept in mind that such a contingent fee arrangement is fundamentally against public policy and, therefore, invalid and unenforceable. The expert witness should be altogether objective and nonpartisan in presenting his opinions. He should keep in mind that he is being retained by the lawyer or party to the action and is not in their employ. He is an independent professional man.

Physician and Hospital Records Retention and Inspection

IT IS AGREED that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an *Interpretation* on this subject which was printed in full in the January 1968 Blue Book issue at page 45.

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4), which was enacted as part of Chapter 301, Laws of Wisconsin, 1959.

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related summaries, but such additional items as: x-rays, laboratory reports and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 21 who are mentally competent; (2) over 21 who are mentally ill; and (3) under 21.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not of legal considerations.
2. A patient of legal age has *3* years within which to sue *for personal injuries*. If a patient elects to sue on *a contract* rather than for alleged *negligence*, he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. We are unaware of any *legal* requirement for accommodating a former patient longer than the suggested 6 years, although there may be sound reasons for retaining them longer. No statute of limitation runs where fraud can be established.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 21 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 21 and mentally ill at the time of his treatment or hospitalization,

or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within a maximum of 8 years.

C. If the patient is a sane minor at the time of the treatment or hospitalization, he must sue for the alleged negligence by the time he reaches 22, unless his guardian did so before he became of age.

4. To the extent that patients' records are retained to assist in collection of accounts, such claims must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

If you receive a request for examination and copying of records, it may not state what specific records are needed. Your records for that patient may go back for 20 years or more.

Before complying with the request of a patient to examine and copy his records, it is suggested that the physician confer, if practical, with the patient or his representative to ascertain *why* he needs his records copied for such a long period of time. If by any chance the records contain material relating to conditions which would be embarrassing to him, or which might involve other members of his immediate family, he might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records for such a long period. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any of such parties.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member. Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Some physicians are requesting not only that the time periods to be copied from a medical record be specified but also that each particular illness be specified in the authorization from the patient.

A number of other precautions are indicated in the *Interpretation* of Chapter 301, Laws of 1959. The physician or anyone designated to handle this matter would do well to review the contents of the *Interpretation before* interviewing the patient or preparing such parts of the medical record as the physician concludes to furnish.

Needless to say, the physician should not proceed under any circumstances without a *written* authorization signed by the patient; and the physician should be satisfied that: (1) the signature is the patient's, (2) he is mentally competent to make the request, and (3) the information is not of the character which would be likely to cause him nervous or other damage. While it is true the patient has what looks like a rather direct and simple legal right, the fact also remains, as to any specific care and treatment furnished by the physician, that the latter has a continuing responsibility toward him for such care and treatment.

The 1963 Legislature authorized the personal representative or the beneficiary of a life insurance policy to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Letters Testamentary" or "Letters of Administration" which are issued by the County Court, Probate Branch. In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) that the person signing the authorization is the beneficiary under the policy. The duty to provide the physician is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized.

Since no wording appears in the statutes prescribing the form of authorization to inspect and copy a patient's record, model forms are not recommended. Sample forms were included in "An Interpretation of Chapter 301; Laws of 1959" which appeared in the 1968 January Blue Book issue at page 45, but they should not be construed as more than suggested guides designed primarily to make clear the illness and period for which inspection and copying are sought.

AMA Ethics

The AMA recently sent the following release to the State Medical Society. It is quoted in full for your information:

> "Is it ethical for a physician, retiring from practice, to sell his patients' records to another physician?

"According to an opinion adopted by the AMA Judicial Council in November, 1967, a physician's records have been developed during the physician-patient relationship. This relationship, referred to in Section 9 of the *Principles of Medical Ethics*, requires that a physician not reveal the confidences entrusted to him in the course of medical attendance. Therefore, since the physician's records summarize these confidences, they too are cloaked with this same protection.

"The Council states further that a transfer of a patient's records, without his consent, would violate this confidence. However, with the patient's consent, his records may be transferred to a physician of his choice and a reasonable charge made for secretarial or duplicating services.

"Furthermore, the judicial Council declares that a physician may not ethically *purchase* such records from a retiring physician or from the estate of a deceased physician." (AMA News Release No. 13, February 1968)

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (2), Wisconsin Statutes, 1967.

PRESCRIBING DRUGS: What the Federal Law Requires

The federal Food, Drug and Cosmetic Act regulates the importation, manufacture, prescription and dispensing of narcotic and dangerous drugs in this country. The physician must be acquainted with the requirements of this Act and conform to its requirements in the prescription and dispensing of these drugs.

Covered by the law are drugs intended for the use of man which are (1) habit forming, (2) so toxic or potentially harmful that they are not safe for use except under the supervision of a qualified practitioner, or (3) new drugs limited under their application for approval to use under professional supervision.

Drugs covered by the law may be dispensed only (1) upon the written prescription of a practitioner licensed by proper state authority to administer such drugs, (2) upon the oral prescription of such a practitioner, provided the oral prescription is promptly reduced to writing and filed by the individual dispensing drugs, or (3) by refilling a written or oral prescription if such refilling was authorized by the practitioner originally prescribing the drug either as a part of the original prescription or by an oral order which must be promptly reduced to writing and filed.

Failure to comply with these procedures results in the drug being deemed misbranded while held for sale and opens the way to severe penalty for the person dispensing it.

When a drug is dispensed, it is exempt from certain of the stringent labeling requirements of the federal law if its label contains the name and address of the party dispensing it, the serial number and date of prescription (or the date of its filling), the name of the practitioner prescribing the drug, and, if included in the prescription, the name of the patient and any directions for the drug's use or cautionary statements. These exemptions do not apply to (1) a drug dispensed in the course of conducting a business of dispensing drugs pursuant to diagnosis by mail or (2) to a drug which is dispensed without observing the procedures dealing with prescriptions, outlined above.

Drugs covered by the law are deemed to be misbranded if at any time prior to their being dispensed their labels fail to bear the statement: "Caution: Federal Law Prohibits Dispensing Without Prescription."

Problems of a Physician's Widow

FOLLOWING the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow will also be presented with the problem of what to do with the physician's narcotics. The Regional Director, Federal Bureau of Narcotics and Dangerous Drugs, Minneapolis, Minn., who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a recent communication to the State Medical Society:

> "The deceased physician's Special Tax Stamp, unused Government order forms, and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused Government order forms (Form 2513) should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wis. 53202. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Director, Bureau of Narcotics and Dangerous Drugs, 402 Federal Building, 110 South Fourth Street, Minneapolis, Minn. 55401, after the drugs have been inventoried on Forms 142, which can be obtained from the Regional Director. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to the Bureau of Narcotics and Dangerous Drugs."

It is important that a widow, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his death may be obtained from the State Board of Pharmacy, State Office Building, Milwaukee.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should *not* be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patients will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should *not* be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney.

Physicians' Guidelines for Delegation of Duties and Functions to Nurses

THE SOCIETY has been asked on a number of occasions whether a certain procedure could be performed by a nurse. Following are some guidelines for a physician to follow when he considers delegating some function, procedure or duty to a nurse.

Three general principles control delegation to nurses. They are:

1. A physician can lawfully delegate to nurses only those functions, procedures or duties which do not require the exercise of his professional judgment.
2. The nurse must have training and experience in the function, procedure or duty to be delegated by the physician.
3. All such functions, procedures or duties must be performed under the direction or supervision or upon the prescription of a physician.

The "practice of medicine" has been described as the primary professional responsibility of the physician for the total care of his patient. Under Wisconsin law a physician is granted an unlimited license. This is legislative recognition of his comprehensive training and his corresponding professional responsibility. Nurses are not granted such a license nor are they trained for such an overall responsibility. It should not be necessary to reiterate that a nurse cannot "practice medicine", or that a physician cannot, except in a genuine emergency, lawfully delegate the power to practice medicine to her wittingly or unwittingly. This is true even though the nurse is willing to perform a function that requires the exercise of the professional judgment of a physician.

The late Louis J. Regan, who was both a doctor of medicine and an attorney, speaking of industrial nursing, sums up the delegation question in the following words:

> "Authority to diagnose, treat, operate or prescribe cannot be delegated."
>
> LOUIS J. REGAN, *Doctor and Patient and the Law*, 3rd Ed., p. 484

Doctor Regan's text also contains the statement on page 483 that a nurse "should assume no responsibility for service outside the field of her professional training." A professional nurse's training is comprehensive in the field of nursing, but it does not encompass training for the practice of medicine. A nurse who is not trained in a procedure and does not have experience in it should not be allowed to perform it. Professional liability for her acts could attach to the physician who ordered a nurse to perform a procedure beyond her competence.

The training of nurses is divided into two levels. The longer and more comprehensive training leads to professional nursing and the lesser to practical nursing. These are separately defined in the Wisconsin Statutes. Section 149.10(1) of the Wisconsin Statutes defines "professional nursing", and Section 149.10(2) defines "practical nursing". These definitions are as follows:

> "149.10 Definitions. (1) Practice of Professional Nursing. The practice of professional nursing within the terms of this chapter means the performance for compensation of any act in the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others, which act requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences, such as the supervision of a patient, the observation and recording of symptoms and reactions, the execution of procedures and techniques in the treatment of the sick *under the general or special supervision or direction of a physician,* the execution of general nursing procedures and techniques and the supervision and direction of trained practical nurses and less skilled assistants."
>
> "(2) Practice of Practical Nursing. The practice of practical nursing under this chapter means the performance for compensation of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, *or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse or physician.* A simple act is one which does not require any substantial nursing skill, knowledge or training, or the application of nursing principles based on biological, physical or social sciences, or the understanding of cause and effect in such acts and is one which is of a nature of those approved by the board for the curriculum of schools for trained practical nurses." (Italics supplied)

Note that in the definition of professional nursing a nurse can treat the sick only "under the general or special supervision or direction of a physician."

Similarly, attention should be given to the italicized wording in subsection (2), quoted above. It says, when read with the first part of the sentence, that "practical nursing" means *not only* simple acts in the care of convalescent and other specified persons, but also "*any act* or *procedure* in the care of the more acutely ill, injured or infirm under the *specific* direction of a [professional] nurse or physician."

The reasonable meaning of the above is that a practical nurse is not limited by statute to what

is described in the first part of subsection (2). A trained practical nurse may *also* perform any act or procedure in the care of the more acutely ill, injured or infirm, *provided* she does so under the specific direction of (a) a professional nurse, or (b) a physician.

Some common sense considerations need to be observed, however. First, neither a physician nor a professional nurse can *lawfully* delegate to a trained practical nurse an act or procedure which would be legally improper for the professional nurse. Second, the phrase "specific direction" reasonably means *in the presence* and under the *immediate supervision* of the physician or professional nurse. This provides the safeguards indicated by the more limited training, skill and experience of the practical nurse.

However, neither type of nurse is authorized by the statutes to diagnose, operate or prescribe. Even the professional nurse can treat the sick *only* under physician supervision or direction.

Supervision or direction of a professional nurse by a physician can take many forms. Physical presence of the physician is not necessarily required in all instances. Many things are done upon the prescription of the physician. In this sense the prescription of a physician means a written order of a physician. This can be either a prescription as used in its normal meaning or an order written in the hospital or other charts.

In the last analysis, the matter becomes one of common sense of the physician, supplemented and guided by his professional training and experience and, equally important, by medical ethics and tradition.

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

(1) He submits with his application a certificate from a licensed physician recommending that a temporary driver's license be issued, and
(2) He is otherwise qualified to obtain a license.

The certificate is a form prepared by the Motor Vehicle Department and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety.

To retain his license the epileptic must present a new certificate every six months.

The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board.

Reference: Section 343.09, Wisconsin Statutes, 1967.

Compilation of Articles on: *The Best of Law and Medicine*

"The Best of Law and Medicine," a compilation of articles appearing in *JAMA* during the period January, 1966, through February, 1968, has been introduced to help familiarize physicians with legal situations with which they may be confronted in their practice.

This collection deals with particular aspects of the impact of law upon the practice of medicine. Demand for reprints of the individual articles became so great that the AMA Committee on Medicolegal Problems suggested that a publication containing the most popular items be produced. The Legal Research Department of the AMA Law Division, which is responsible for content, selected the articles it felt would provide both interesting and useful reference sources for physicians, as well as others interested in this aspect of the law.

Medical liability, medical health and medical evidence represent only a few of the eight major categories covered by the handbook. The 8½"x11", 184-page paperback is *not* intended as a do-it-yourself law book for physicians, nor is it to be considered a substitute for personal legal advice from an attorney.

Residents in the U.S., U.S. Possessions, Canada and Mexico may secure a copy for $1.50. Medical students, hospital interns and residents in these areas may receive it for only 75¢. The price in all other countries is $1.75. Orders should be coded "OP-179" and directed to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc., 6870 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 53202.

Catholic Social Services of the Archdiocese of Milwaukee, Inc., 207 East Michigan Street, Milwaukee 53202.

Catholic Charities Bureau, 1209 Hughitt Ave., Superior 54881.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3126 West Highland Boulevard, Milwaukee 53208.

Jewish Family & Children's Service, The Plankinton Bldg., Suite 3185, 161 W. Wisconsin Avenue, Milwaukee 53203.

Methodist Children's Services of Wisconsin, 303 Price Place, Lincoln Bldg., Madison 53711.

PUBLIC AGENCIES:

*Wisconsin Division of Family Services, Room 384, State Office Bldg., Madison 53702

*Milwaukee County Department of Public Welfare, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

LICENSED MATERNITY HOMES:

Lutheran Maternity Home, 1910 South Ave., La Crosse 54601.

*Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Hall Maternity Home (Catholic), 1233 North 23rd Street, Milwaukee 53205.

St. Francis Maternity Residence (Catholic), 11th and Market Streets, La Crosse 54601.

Marian Hall (Catholic), 1725 Dousman Street, Green Bay 54303.

Fees for care in licensed maternity homes vary from $150 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

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* Nondenominational.

POISON INFORMATION CENTERS . . .

- approved by the Wisconsin Division of Health offer information on the chemical composition of brand-name products on a 24-hour day basis. Files are provided and kept up-to-date by the National Clearinghouse for Poison Control.
- recommend treatment to professional people or in certain emergencies, first aid procedure to lay callers.
- provide treatment for patients.
- keep a record of calls received, treatment advised or given, and disposition of case.
- report monthly to the Division of Health.

are located at:

Eau Claire
Luther Hospital
Phone: 832–6611 Ext. 347

Green Bay
Bellin Memorial Hospital
Phone: 435–5311 Ext. 257

Kenosha
Kenosha Memorial Hospital
Phone: 654–5311 Ext. 254

Madison
University Hospitals
Phone: 262–3702

Milwaukee
Children's Hospital
Phone: 344–7100

POISON CONTROL CENTERS . . .

- exist in many hospitals, including those listed above as Poison Information Centers. Not all Poison Control Centers are set up to give 24-hour service.
- provide treatment for patients.
- have standard references on toxicology and can answer many questions about potential poisons and treatment of cases. However, they do not have a complete file of the chemical composition of brand-name products such as the Poison Information Centers have.

This information provided by the
WISCONSIN DIVISION OF HEALTH
P. O. Box 309 Madison, Wis. 53701

THE STATE MEDICAL SOCIETY of Wisconsin maintains close relationship with the University of Wisconsin Medical Library so there is no duplication of effort or facilities in the areas of medical library service and resources. The UW Medical Library is conveniently located only three miles from the Society headquarters in Madison. Because of these circumstances the Society office has library facilities for internal usage only. Should a physician request such information or material from the Society that is normally available from the UW Medical Library, the Society forwards the request to the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706. The State Medical Society also contributes its review books to the Medical Library. Medical Library Service distributes these books to University faculty for review. The reviews are sent to the Wisconsin Medical Journal *for publication and the books are returned to the Medical Library where they are catalogued and available to library users. The Society's contribution of new books to the University of Wisconsin Medical Library amounts to more than $1,000 annually. The Society also receives over 200 medical journals on an exchange basis with other state medical societies, specialty societies, and other scientific and health organizations, local, state, national, and international. These, too, are given to the Medical Library after perusal by Society staff. This represents, perhaps, $1,000 in savings to the Medical Library. In addition, books of historical value, contributed to the Society's Section on Medical History, often are given to the Medical Library's historical collection which is considered one of the best in the country. The relationship of the Medical Library and the State Medical Society has been mutually rewarding. Physicians are urged to utilize the services of the University of Wisconsin Medical Library.*

—EDITOR

The Quest for Information

By VIRGINIA HOLTZ, Madison, Wisconsin

FOR OVER A year now, Wisconsin has been the scene of a rapidly developing medical information network. Communication between medical libraries and information services of all sizes has led to budding cooperative efforts and service chains which in their fullest development will enable any physician or other health science personnel in the state to acquire needed information in the shortest possible time.

In order to best utilize the network, or indeed information resources anywhere, it is important that the requester become familiar with the basic rules of the information game. There are several variations in need which dictate differing approaches.

The simplest and most frequently used service in the state today is filling the request for an article to match a citation furnished by the inquirer. An adequate and correct citation can proceed along the information chain and produce results in a matter of hours or at most, a few days. Most libraries promise same-day service on this sort of negotiation. However this speed of service is conditional on a reference that is both accurate and complete. A full citation consists of the following elements:

FOR BOOKS	FOR JOURNAL ARTICLES
*Author	Author
*Title	Title of article
Publisher	*Title of journal
Date	*Volume number
Source of citation or verification	*Inclusive pagination
	*Year of publication
	Source of citation or verification

A reference containing all of the above mentioned elements is not only easily located or corrected, but eligible for forwarding to the Midwest Regional Medical Library Service at the Crerar Library in Chicago, our latest government sponsored resource, and other out-of-state information centers, such as the National Library of Medicine.

Often the harried practitioner will find himself without some of the necessary items of information. If local resources do not provide tools for completing the citation (the *Index Medicus* is invaluable for this sort of job) requests containing only the starred items in the list can be honored by most libraries in the state.

Accuracy in transcribing a citation is of the utmost importance. A misspelled or incorrectly remembered author's name can lead to a lengthy and wasteful search. The same can be true of an inaccurately remembered title. If any element in a request is in question, it should be followed by a question mark in parentheses (?). It is better to include a piece of questionable information, tagged in this way, than to eliminate it altogether, since any clue to an elusive reference is better than no information at all.

Journal articles, because of the many items of information involved are at the same time simpler and more difficult: simpler, because they offer so many avenues of approach (if one element in the citation is wrong, another may point the way to the correct item); more difficult because they offer more opportunity for error or omission. If only the four starred items on the list of elements are available, the journal can be searched in the statewide network, but probably the citation cannot be corrected

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if in error, or forwarded beyond the state level. If any one of the four is missing, at least one other item from the list, or as an alternative, the subject matter of the article sought, must be given.

In some desperate cases, relatively little is known about the item wanted. However, the potential borrower must know the subject and should give as much information on that score as possible. He may or may not know the author. Hopefully he knows approximately when the item was published. Sometimes he knows in what journal the article appeared. Again, as much information as possible should be provided, with doubtful items appropriately marked. The most common errors in this sort of request are the requester's mistaking the date on which he read the article for the date of publication, his confusing similar specialty journals, or his confusing the part of the article of interest to him as the topic of the entire article. Still, every clue is helpful.

Librarians have, in known instances, responded valiantly and successfully to the bare minimum in citations. A request for "V.240 p. 21" was filled because an experienced medical librarian recognized that only the *American Journal of the Medical Sciences* was old enough, at that point in time, to have reached that level in volume numbering. A plea for Ibid 2:63, 1954 was matched to a request received from the same inquirer on the previous day and the order filled. This aspect of the game, while intensely challenging to the searcher, does not contribute to speed of delivery.

In short, for the speediest service, the citation should be as complete and accurate as possible, giving all known information with suspect elements marked with a question mark as indicated. A doubtful request or one for a possibly rare journal should include the source of the citation or verification. Simply knowing where the needy party found or verified his original citation is often extremely helpful in assisting the librarian to track down an elusive item or justify a search at an out-of-state source.

Proper Subject Request

The art of framing a proper subject request is another game entirely. It requires the same talents for accuracy and completeness, but is played within a much looser framework. In submitting a subject request one must in a sense be both specific and general. The specific problem engaging the physician should be carefully circumscribed to eliminate the provision of any material not relevant to his needs. At the same time the problem should be set in its proper perspective by a description of the case or surrounding circumstances which contribute to defining the central problem. For instance, it is futile to request material concerning the possible hemorrhagic complications of a certain procedure without indicating that the patient concerned was simultaneously under treatment with anticoagulants for another condition. It is equally misleading to ask for information about the complications of pregnancy when you really want to see articles on complication of pregnancy in human females exposed to rubella during the first trimester of pregnancy or on complications in all diabetic mammals. It may be that little or nothing in the literature covers the precise situation, but an adequate request gives the searcher the option of going to the next most general level and furnishing the most relevant material available.

Additional Information Helpful

Types of additional information which are helpful to the searcher are: age of patient and sex group if this is relevant to the question; a notation indicating if only clinical material is wanted or laboratory experiments as well; what aspects of a disease entity are pertinent to the question, e.g. therapy, diagnosis, etiology, complication etc.; the purpose for which the material is to be used, since a congress paper, a talk to a group of laymen or material for a report as a medical witness may all require different approaches; the part of the body involved as in the case of certain neoplasms; the time span to be covered in the search; an estimate of the number of articles wanted; the languages read by the requesting party; and any deadlines. Obviously a great many more areas could be defined, depending on the nature of the subject. The more time spent in carefully framing the question, the more likely it is that the resulting answer will be satisfactory.

A cautionary note here: if a subject request is to be placed by telephone rather than letter, the call should be made by the person who wants the information. This is not a job which can be delegated successfully to a clerk or secretary. Most searchers will have some idea of the problems they will meet in the search and will want to query the requester further about certain facets of the problem. Nothing is more defeating than to attempt problem definition with someone who knows no more about the problem than you, and much time is wasted. Prior permission to provide photocopy when necessary (possibly with a limitation on amount to be spent) is also effective.

Since speed of service has become such an important element in information transfer, several RUSH codes have been established in the state. All requests are given the speediest possible routine service. For those emergencies which demand something faster, two categories of service are generally though not universally available. The first is RUSH. Items marked in this manner are processed and mailed before all other requests of its kind are handled, rather than waiting their turn. Items marked RUSH SPECIAL are given the same priority as RUSH items, and in addition are mailed at special rates (first class, air mail, special handling or special delivery) at the borrower's expense, to insure faster delivery. It is obvious that the RUSH channels, if misused, could become so overworked as to be ineffective. Thus they should be used with discretion.

To insure this sort of special handling the message to the library or information center should be marked RUSH or RUSH SPECIAL, preferably in red, in a prominent place. If the request is submitted via the telephone, a RUSH category should be specifically indicated, as many calls are received for non-rush items. Telegraph messages are generally assumed to be RUSH, but it is still safest to indicate this status in the message.

Etiquette Important, Too

As in most other areas there are certain elements of etiquette to be observed in the information transfer process. For example, long lists of citations should not be given via the telephone. Most libraries have placed arbitrary limits (usually 5 or 6 items) on the number of citations they will take by this route. Not only is the telephone request a real time-waster for people on both ends of the line, but unless each word is carefully coded many mistakes are likely. Words such as neurology and urology, and sixteen and sixty are easily confused. Citation verification for the purpose of publication is seldom an urgent matter and except in very rare cases should not be done via the telephone. If each institution were to subscribe to the *Index Medicus*, the majority of this sort of work could be done in the local hospital or clinic and would not clog the channels of the information network.

The last item for consideration is the complete literature search. While the equivalent of such a search is sometimes done in the case of an elusive piece of information, by and large there is so much literature on any one subject, that the difficulty lies in selecting a manageable and representative sampling for the busy practitioner rather than in finding enough material. Anyone with so overwhelming an interest in a subject as to want a complete literature search of today's masses of health-related literature should expect either to spend a great deal of his own time on the project, ask for assistance in locating special bibliographies, or expect to utilize paid assistance. Often much of the difficulty here can be overcome by merely setting a time limit on the search as most centers are willing to search a subject fairly thoroughly for a matter of years; perhaps submitting for your consideration Xeroxed and marked pages of *Index Medicus* or one of its derivative bibliographies, or the typed product of a selective hand search.

With these pointers in mind you should be able to utilize the new network to its fullest capacity. As new developments occur in the health information field, those which are applicable will doubtless be worked into the system. However many innovations occur, it will still be essential that these few elements of accuracy, specificity, completeness and etiquette be observed for the best in information service.

GUIDES FOR SMALLER PLANTS IN INDUSTRY

Suggested Basic First Aid Facilities, Equipment and Supplies for a Small Plant

Tentative Outline—Occupational Health Programs in Small Business Establishments: Guide for Employers, Physicians, Nurses, and First Aid Personnel

These guides are available upon request to the State Division of Health, Department of Health and Social Services, Box 309, Madison, Wis. 53701.

State Medical Society of Wisconsin

SPEAKERS SERVICE

for

COUNTY MEDICAL SOCIETY MEETINGS

and

COUNTY DISTRICT MEETINGS

County medical societies are urged to use this service which is now in its sixth consecutive year of operation. Speakers from throughout the state as well as those from the two medical schools and the State Division of Health are available through application to the State Medical Society. Applications must be filed at least 30 days before a meeting in order to qualify the speaker for an honorariam and travel expenses. (No speakers are furnished during April and May.)

All areas of scientific medicine are represented, and societies are urged to arrange for at least four scientific programs per year. Other subjects on which speakers are available include legislation, health insurance, interprofessional meetings, school health, mental health, care of the aged, occupational health, medical press relations, maternal mortality, glaucoma detection, cancer and heart, orthopedic and heart clinics.

Request application forms from Edgar S. Gordon, MD, Chairman, Commission on Scientific Medicine, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Sponsored by

COMMISSION ON SCIENTIFIC MEDICINE AND CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION OF THE STATE MEDICAL SOCIETY

in cooperation with

POSTGRADUATE PROGRAM OF MERCK SHARP & DOHME, WISCONSIN DIVISION OF HEALTH, AMERICAN CANCER SOCIETY—WISCONSIN DIVISION, WISCONSIN HEART ASSOCIATION, MARQUETTE SCHOOL OF MEDICINE, AND UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

Wisconsin Legislature

DIRECTORY OF MEMBERS

Prepared by the Wisconsin Taxpayers Alliance, Madison, Wisconsin

SENATE DISTRICTS

ASSEMBLY DISTRICTS

TAX DEDUCTIBILITY OF HEALTH AND ACCIDENT INSURANCE

As a result of Public Law 89–97, one-half of medical care insurance premiums up to a maximum of $150.00 are fully deductible. Additional medical care premiums may be included with other medical expenses and are subject to the limited deduction of the excess of medical expenses over 3% of adjusted gross income up to the applicable maximum.

Public Law 89–87 also reversed the advantages the courts had given taxpayers by permitting total premiums of health and accident policies which provided indemnity for accidental loss of life, limb, sight or time, to be deductible medical expenses for federal income tax purposes.* Only that portion of such policies which is allocable to medical care is now deductible and *only* if the charge for medical care is separately stated in the policy or in a statement sent to the policyholder by the insurance company. In addition, the charge for medical care on a combination policy is eligible for a medical expense deduction only if not unreasonably large in relation to the total premium under the contract.

Finally, the liberalized medical expense deductions which were available to taxpayers over the age of 65 have been removed. All taxpayers, whatever their age, are now subject to the same general rules. Disabled taxpayers over 65 still are eligible for a higher maximum medical expense deduction.

The same rules as are set out above also apply for 1967 Wisconsin income tax purposes.

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* Thus, the tax benefits noted at page 59 of the January 1967 issue of the *Wisconsin Medical Journal* are no longer available.

State Officers

Governer—Knowles, Warren P. (R), 251 W. 2nd St., New Richmond 54017

Lt. Governor—Olson, Jack B. (R), 834 Meadow La., Wisconsin Dells 53965

Sec. of State—Zimmerman, Robert C. (R), 4502 Hammersley Rd., Madison 53711

State Treasurer—Clemens, Harold W. (R), 272 Lac La Belle Dr., Oconomowoc 53066

Attorney General—Warren, Robert W. (R), 200 W. Briar La., Green Bay 54301

Members of Congress from Wisconsin

SENATORS

Senate Office Bldg., Washington, D.C. 20510

Proxmire, William (D), 4613 Buckeye Rd., Madison 53716

Nelson, Gaylord (D), 5750 Bittersweet Pl., Madison 53705

REPRESENTATIVES

House Office Bldg., Washington, D.C. 20515

Dist.

1. Schadeberg, Henry C. (R), 333 Emerson St., Burlington 53105
2. Kastenmeier, Robert W. (D), 300 N. Water St., Watertown 53094
3. Thomson, Vernon W. (R), 578 E. 2nd St., Richland Center 53581
4. Zablocki, Clement J. (D), 3245 W. Drury La., Milwaukee 53215
5. Reuss, Henry S. (D), 925 E. Wells St., Milwaukee 53202
6. Steiger, William A. (R), 684 Oak St., Oshkosh 54901
7. Laird, Melvin R. (R), 313 E. 3rd St., Marshfield 54449
8. Byrnes, John W. (R), 406 N. Washington St., Green Bay 54301
9. Davis, Glenn R. (R), 2300 Springdale Rd., New Berlin 53151
0. O'Konski, Alvin E. (R), Mercer 54547

Members of the 1969 Wisconsin Senate

Dist.	Name (Party)	District (Counties)	Address
1.	–Meunier, Alex J. (R)	Door, Kewaunee, Manitowoc	R. 1, Sturgeon Bay 54235
2.	Lotto, Myron P. (R)	1st, 2nd assembly districts, Brown; Calumet	R. 3, Green Bay 54301
3.	–Kendziorski, Casimir (D)	11th, 12th, 14th assembly districts, Milwaukee	2025 S. 14th St., Milwaukee 53204
4.	Soik, Nile (R)	3rd, 18th, 25th assembly districts, Milwaukee	6266 N. Santa Monica Blvd., Whitefish Bay 53217
5.	–Schuele, Wilfred (D)	2nd, 9th, 15th assembly districts, Milwaukee	3036 N. 84th St., Milwaukee 53222
6.	*Schreiber, Martin J., Jr. (D)	1st, 5th, 7th assembly districts, Milwaukee	3128 N. 50th St., Milwaukee 53216
7.	–McParland, Leland S. (D)	17th, 19th, 24th assembly districts, Milwaukee	4757 S. Packard Ave., Cudahy 53110
8.	*Busby, Allen J. (R)	20th, 21st, 22nd assembly districts, Milwaukee	1673 S. 53rd St., Milwaukee 53214
9.	–Sussman, Norman (D)	4th, 6th, 13th assembly districts, Milwaukee	1621 W. Wis. Ave., Milwaukee 53233
10.	*Knowles, Robert P. (R)	Buffalo, Pepin, Pierce, Burnett, Polk, St. Croix	New Richmond
11.	–Whittow, Wayne F. (D)	8th, 10th, 16th assembly districts, Milwaukee	4921 W. Washington Blvd., Milwaukee 53208
12.	*Krueger, Clifford W. (R)	Clark, Forest, Oneida, Vilas, Lincoln, Taylor	122 N. State St., Merrill 54452
13.	–Panzer, Frank E. (R)	1st assembly district, Dodge; Jefferson, Washington	R. 1, Brownsville 53006
14.	*Lorge, Gerald D. (R)	Outagamie, Waupaca	Bear Creek 54922
15.	–Swan, James D. (R)	1st, 3rd assembly districts, Rock; Walworth	R. 2, Elkhorn 53121
16.	*Thompson, Carl W. (D)	4th, 5th assembly districts, Dane; 2nd assembly district, Rock	R. 3, Stoughton 53589
17.	–Roseleip, Gordon W. (R)	Grant, Green, Iowa, Lafayette, Richland	Box 167, Darlington 53530
18.	*Hollander, Walter G. (R)	2nd assembly district, Dodge; Fond du Lac	R. 1, Rosendale 54974
19.	–Draheim, William A. (R)	Winnebago	913 Hewitt St., Neenah 54956
20.	*Keppler, Ernest C. (R)	Ozaukee, Sheboygan	909 New York Ave., Sheboygan 53081
21.	–Dorman, Henry (D)	1st, 2nd assembly districts, Racine	422 16th St., Racine 53403
22.	*Lourigan, Joseph (D)	Kenosha	3604 19th Ave., Kenosha 53140
23.	–Rasmusen, Holger B. (R)	Barron, Chippewa, Dunn, Washburn	722 Franklin St., Spooner 54801
24.	Heinzen, Raymond F. (R)	Green Lake, Waushara, Portage, Wood	R. 5, Marshfield 54449
25.	–Cirilli, Arthur A. (R)	Ashland, Bayfield, Douglas, Iron, Price, Rusk, Sawyer	909 E. 4th St., Superior 54880
26.	*Risser, Fred A. (D)	1st, 2nd, 3rd assembly districts, Dane	5409 Esther Beach Rd., Madison 53713
27.	–Terry, Walter E. (R)	Adams, Columbia, Juneau, Marquette, Sauk	R. 3, Baraboo 53913
28.	Devitt, James C. (R)	23rd assembly district, Milwaukee; 3rd assembly district, Racine; 4th assembly district, Waukesha	5151 S. Root River Pkwy., Greenfield 53228
29.	–Chilsen, Walter John (R)	Marathon, Menominee, Shawano	R. 5, Box 25, Wausau 54401
30.	*LaFave, Reuben (R)	3rd assembly district, Brown; Florence, Marinette, Langlade, Oconto	R. 1, Box 89A, Oconto 54153
31.	–Johnson, Raymond C. (R)	Eau Claire, Jackson, Monroe, Trempealeau	221 N. 12th St., Eau Claire 54701
32.	Knutson, Milo C. (R)	Crawford, Vernon, La Crosse	804 Cass St., La Crosse 54601
33.	–Dempsey, Chester E. (R)	1st, 2nd, 3rd assembly districts, Waukesha	R. 1, Hartland 53029

– Hold-over senator from 1967 legislature.

* Served in 1967 senate.

Senate terms for even-numbered districts expire on the second Wednesday of January 1973 and odd-numbered districts on the second Wednesday of January 1971.

Members of the 1969 Wisconsin Assembly

District (Counties)	Name (Party)	Address
Adams, Juneau and Marquette	°Thompson, Tommy G. (R)	1407 Academy St., Elroy 53929
Ashland, Bayfield and Iron	Korpela, Ernest J. (D)	227 W. 3rd St., Washburn 54891
Barron and Washburn	°Van Hollen, John C. (R)	720 Lakeview Dr., Chetek 54728
Bayfield (See Ashland)		
Brown, 1st	°Quinn, Jerome (R)	137 N. Oakland Ave., Green Bay 54303
Brown, 2nd	°Kafka, Lawrence J. (R)	R. 3, Denmark 54208
Brown, 3rd	°Vanderperren, Cletus (D)	R. 5, Green Bay 54301
Buffalo, Pepin and Pierce	°York, Stanley (R)	118 N. 3rd St., River Falls 54022
Burnett and Polk	°Dueholm, Harvey L. (D)	R. 2, Luck 54853
Calumet	°Hephner, Gervase A. (D)	618 S. Madison St., Chilton 53014
Chippewa	°Peloquin, Bruce S. (D)	R. 5, Box 311, Chippewa Falls 54729
Clark	Nikolay, Frank L. (D)	Abbotsford 54405
Columbia	°Packard, Wesley L. (R)	143 S. Main St., Lodi 53555
Crawford and Vernon	°Lewison, Bernard (R)	11 S. Washington Hgts., Viroqua 54665
Dane, 1st	°Anderson, Norman C. (D)	5325 Marsh Rd., Madison 53704
Dane, 2nd	°Nager, Edward (D)	840 Spaight St., Madison 53703
Dane, 3rd	°Uehling, Robert O. (R)	4330 Keating Ter., Madison 53711
Dane, 4th	°Weisensel, Russel R. (R)	Twin Lane Rd., Sun Prairie 53590
Dane, 5th	°O'Malley, David D. (D)	315 W. Main St., Waunakee 53597
Dodge, 1st	°Luckhardt, Mrs. Esther D. (R)	211 N. Hubbard St., Horicon 53032
Dodge, 2nd	°Nitschke, Elmer C. (R)	208 Hamilton St., Beaver Dam 53916
Door and Kewaunee	°Johnson, Lawrence H. (R)	R. 2, Algoma 54201
Douglas	Stack, Edward (D)	1420 John Ave., Superior 54880
Dunn	°Baldus, Alvin (D)	1901 S. Broadway, Menomonie 54751
†Eau Claire, 1st	Looby, Joseph L. (D)	1156 E. Madison St., Eau Claire 54701
Eau Claire, 2nd	°Mato, Louis V. (D)	Fairchild 54741
Florence and Marinette	La Fave, William G. (R)	R. 1, Box 223, Peshtigo 54157
Fond du Lac, 1st	°McEssy, Earl F. (R)	361 Forest Ave., Fond du Lac 54935
Fond du Lac, 2nd	°Schwefel, William S. (R)	R. 1, Oakfield 53065
Forest, Oneida and Vilas	°Alfonsi, Paul R. (R)	Minocqua 54548
Grant	°Azim, James N., Jr. (R)	Muscoda 53573
Green and Lafayette	°Tregoning, Joseph (R)	R. 2, Shullsburg 53586
Green Lake and Waushara	Wilcox, Jon P. (R)	460 S. Oxford St., Wautoma 54982
Iowa and Richland	°Bock, Gregor J. (R)	Highland 53543
Iron (See Ashland)		
Jackson and Trempealeau	°Radcliffe, John (D)	Strum 54770
Jefferson	°Wackett, Byron F. (R)	100 Oak Hill Ct., Watertown 53094
Juneau (See Adams)		
Kenosha, 1st	°Molinaro, George (D)	424 44th St., Kenosha 53140
Kenosha, 2nd	°Olson, Russell A. (R)	Bassett 53101
Kewaunee (See Door)		
La Crosse, 1st	Greider, Gerald A. (R)	1729 Adams St., La Crosse 54601
La Crosse, 2nd	°Nuttelman, Norbert (R)	R. 1, West Salem 54669
Lafayette (See Green)		
Langlade and Oconto	°McDougal, Milton (R)	402 Chestnut Ave., Oconto Falls 54154
Lincoln and Taylor	°Sweda, Joseph (D)	Lublin 54447
Manitowoc, 1st	Helgeson, Donald K. (R)	937 N. 5th St., Manitowoc 54220
Manitowoc, 2nd	°Bolle, Everett E. (D)	Francis Creek 54214
Marathon, 1st	Day, Laurence J. (D)	R. 1, Eland 54427
Marathon, 2nd	°Obey, David R. (D)	515 N. 9th Ave., Wausau 54401
Marinette (See Florence)		
Marquette (See Adams)		
Menominee and Shawano	°Grover, Herbert J. (D)	R. 3, Shawano 54166
Milwaukee, 1st	°Lipscomb, Mark G., Jr. (D)	5349 N. Dexter Ave., Milwaukee 53209
Milwaukee, 2nd	°Jones, Joseph E. (D)	4285 N. 26th St., Milwaukee 53209
Milwaukee, 3rd	Conta, Dennis (D)	3489 N. Hackett Ave., Milwaukee 53211
Milwaukee, 4th	Sanasarian, Harout (D)	1111 N. Astor St., Milwaukee 53202
Milwaukee, 5th	°Sicula, Paul E. (D)	3287 N. 48th St., Milwaukee 53216
Milwaukee, 6th	°Barbee, Lloyd A. (D)	321 E. Meinecke Ave., Milwaukee 53212
Milwaukee, 7th	°Johnson, William A. (D)	3403 N. 22nd St., Milwaukee 53206
Milwaukee, 8th	Czerwinski, Joseph C. (D)	1230 S. 34th St., Milwaukee 53215
Milwaukee, 9th	Jackson, Robert, L., Jr. (D)	7869 N. 57th St., Milwaukee 53223
Milwaukee, 10th	°Kessler, Frederick P. (D)	2719 W. Juneau Ave., Milwaukee 53208
Milwaukee, 11th	°Tobiasz, Raymond J. (D)	3145 S. 50th St., Milwaukee 53219
Milwaukee, 12th	°Orlich, Sam L. (D)	1307 W. Mineral St., Milwaukee 53204
Milwaukee, 13th	°Parys, Ronald G. (D)	1221 E. Clarke St., Milwaukee 53212
Milwaukee, 14th	Kleczka, Gerald D. (D)	3427 S. 9th Pl., Milwaukee 53215
Milwaukee, 15th	Tamms, Erwin G. (R)	2808 N. 89th St., Milwaukee 53222
Milwaukee, 16th	°Pabst, Richard E. (D)	457A S. 74th St., Milwaukee 53214
Milwaukee, 17th	°McCormick, John E. (D)	2954 S. Wentworth Ave. Milwaukee 53207
Milwaukee, 18th	Schneeberg, Ervin F. (R)	8540 N. 42nd St., Brown Deer 53209
Milwaukee, 19th	°Hanna, Daniel D. (D)	2501 W. Henry Ave. Milwaukee 53221
Milwaukee, 20th	°Klicka, George H. (R)	2115 N. 86th St., Wauwatosa 53226
Milwaukee, 21st	Lynn, James J. (D)	1126 S. 94th St., West Allis 53214
Milwaukee, 22nd	°Huber, Robert T. (D)	2228 S. 78th St., Wes Allis 53219
Milwaukee, 23rd	Wing, Jerry J. (R)	5140 S. 37th St., Greenfield 53221
Milwaukee, 24th	°Atkinson, William P. (D)	1115 16th Ave., Soutl Milwaukee 53172
Milwaukee, 25th	Sensenbrenner, F. James, Jr. (R)	2800 E. Menlo Blvd. Shorewood 53211
Monroe	°Kenyon, Kyle (R)	R. 4, Tomah 54660
Oconto (See Langlade)		
Oneida (See Forest)		
Outagamie, 1st	°Froehlich, Harold V. (R)	421 W. 6th St., Appleton 54911
Outagamie, 2nd	°Rogers, William J. (D)	1317 Hillcrest Dr., Kaukauna 54130
Outagamie, 3rd	°Conradt, Ervin W. (R)	R. 2, Shiocton 54170
Ozaukee	Schowalter, Herbert J. (R)	642 S. Main St., Saukville 53080
Pepin (See Buffalo)		
Pierce (See Buffalo)		
Polk (See Burnett)		
Portage	°Groshek, Leonard A. (D)	901 2nd St., Stevens Point 54481
Price, Rusk and Sawyer	°Hutnik, Willis J. (R)	716 E. 3rd St., N., Ladysmith 54848
Racine, 1st	°Warren, Earl W. (D)	2809 Virginia St., Racine 53405
Racine, 2nd	°Brown, Manny S. (D)	2817 Ruby Ave., Racine 53402
Racine, 3rd	°Stalbaum, Merrill E. (R)	R. 1, Box 38, Waterforc 53185
Richland (See Iowa)		
Rock, 1st	°Mittness, Lewis T. (D)	730 N. Ringold St., Janesville 53545
Rock, 2nd	°Blanchard, Mrs. Carolyn J. (R)	506 Chamberlain St., Edgerton 53534
Rock, 3rd	°Belting, George B. (R)	2041 E. Ridge Rd., Beloit 53511
Rusk (See Price)		
St. Croix	°Boche, Robert M. (R)	Star Prairie 54026
Sauk	°Laper, Oscar A. (R)	R. 1, Rock Springs 53961
Sawyer (See Price)		
Shawano (See Menominee)		
Sheboygan, 1st	°Otte, Carl (D)	1440 S. 22nd St., Sheboygan 53081
Sheboygan, 2nd	Boeckmann, Vernon R. (D)	R. 2, Plymouth 53073
Taylor (See Lincoln)		
Trempealeau (See Jackson)		
Vernon (See Crawford)		
Vilas (See Forest)		
Walworth	°Wilger, Clarence J. (R)	R. 4, Elkhorn 53121
Washburn (See Barron)		
Washington	°Schroeder, Frederick C. (R)	R. 1, Box 150, West Bend 53095
Waukesha, 1st	°Merkel, Kenneth J. (R)	3405 N. Brookfield Rd. Brookfield 53005
Waukesha, 2nd	Alberts, John M. (R)	1228 W. Wis. Ave., Oconomowoo 53066
Waukesha, 3rd	°Mathews, Vincent R. (D)	530 Linden St., Waukesha 53186
Waukesha, 4th	°Shabaz, John C. (R)	21425 W. Glengarry Rd., New Berlin 53151
Waupaca	Byers, Francis R. (R)	Garfield Ave., Marion 54950
Waushara (See Green Lake)		
Winnebago, 1st	°Steinhilber, Jack D. (R)	1748 Southland Ave., Oshkosh 54901
Winnebago, 2nd	Bradley, Gordon R. (R)	2644 Elo Rd., Oshkosl 54901
Winnebago, 3rd	°Martin, David O. (R)	521 Haylett St., Neenal 54956
Wood, 1st	Parkin, John (R)	907 S. Oak Ave., Marshfield 54449
Wood, 2nd	°Gee, Harvey F. (R)	170 14th Ave., S., Wisconsin Rapids 54494

° Served in 1967 assembly.

† Election result has been challenged by Wilmer R. Waters, 1417 Birney St., Eau Claire, the Republican candidate.

See following pages for maps showing assembly districts in counties which have more than one assembly district.

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1969, you must pay the final installment of the estimated federal and Wisconsin tax on your 1968 income. This may necessitate an amended declaration by that date if you find that you underestimated 1968 income. A final income tax return for 1968, filed on or before January 31, 1969, accompanied by payment in full of the amount computed on the return as payable, will be treated as an amended declaration as of January 15 for both Wisconsin and federal purposes. Penalties are assessed for certain underestimating of taxes. These penalties and their avoidance are discussed in Section 6 below.

2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1968 on Forms W-3 (Federal) and WT-7 (Wisconsin). These are summary report forms for the Forms W-2 (Federal) and WT-9 (Wisconsin), respectively.
   (2) Furnish a statement to employees on Forms W-2 (Federal) and WT-9 (Wisconsin) showing wages paid and amount of tax withheld during the calendar year 1968.
   (3) File fourth quarterly return for 1968 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (4) Furnish a statement to payees to whom interest, rent, compensation not reported on Form W-2 (Federal) and similar types of payments have been paid on Form 1099 (Federal).
   (5) File annual federal unemployment tax return on Form 940 (Federal).

3. By February 28, you must file a summary report on Form 1096 (Federal) attaching copies of the Forms 1099 (Federal) furnished to payees.

4. By April 15, you must:
   (1) File your personal income tax returns on Forms 1040 (Federal) and Form 1 (Wisconsin).
   (2) If a partnership, file your partnership income tax return on Forms 1065 (Federal) and 3 (Wisconsin).
   (3) File and furnish a copy to payees to whom interest, rent, compensation not reported on Forms WT-9 (Wisconsin) and similar types of payments have been paid on Form 9b (Wisconsin).

5. During 1969, you must:
   (1) File quarterly returns by April 30, July 31, and October 31 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (2) File quarterly Wisconsin employer's unemployment compensation reports by the dates stated on the Form UC-101 furnished quarterly by the Department of Industry, Labor and Human Relations.

6. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1969 income must be shown on Wisconsin and federal declaration forms which have to be filed, together with the estimated tax then due, by April 15, 1969. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1969. As to the final installment due in January, 1970, follow the alternative procedure described in Section 1, above.

   Excluding cases of willful understatement, a penalty is provided for underpaying taxes on declarations of estimated income. This penalty is a 6 percent assessment computed for each installment date on the difference between the amount paid and 80 percent of the amount which should have been paid. The penalty can be avoided if your quarterly installment payments meet one of four exception provisions following. (1) You may pay an amount at least equal to the tax shown on your return for the preceding taxable year. (2) Or, you may estimate your tax on the facts shown on your return for the preceding taxable year, but using current tax rates and personal exemptions. (3) Or, you may pay with each quarterly installment an amount at least equal to 80 percent of a tax then computed as if your income for the balance of the year remaining were to continue at the same rate. (4) Or, you may pay with each quarterly installment an amount at least equal to 90 percent of a tax computed at current rates on the actual taxable income for the months preceding each quarterly installment.

7. Comments on Preceding Information.

   The preceding tax information is general and not exhaustive. Alternate methods of fulfilling these tax requirements do exist. Different forms may be required. The forms and instructional sheets furnished with them should be consulted to determine appropriate alternate methods and forms to use.

The deadline dates apply to taxpayers who use the calendar year as their fiscal year.

Returns and filing dates for personal service corporations differ for certain of those discussed.

ANNUAL REGISTRATION IN WISCONSIN

Register with the Secretary, Medical Examining Board, Department of Regulation & Licensing, State of Wisconsin, 110 No. Henry Street, Madison, Wis. 53703, in the month of January. This registration will be on a form furnished by the Medical Examining Board and should be accompanied by the registration fee shown on that form. Sec. 147.175, Wis. Statutes.

ANNUAL NARCOTICS REGISTRATION

1. Register with the District Director, Internal Revenue Service, Milwaukee, Wisconsin, as required by the federal narcotics law, and pay the annual tax of $1.00 *before* July 1, 1969. I.R.C. 1954, Sec. 4751 and 4753. You are subject to penalties for overlooking either the registration or the tax.
2. Notify the District Director, Internal Revenue Service, Milwaukee, Wisconsin, of changes in place or places of business within 30 days to insure the legality of your narcotics license.

COMMITMENT REGISTRATION

Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin, 53701.

Control of LSD

The Wisconsin Legislature has added LSD and other hallucinogens to the list of "dangerous drugs."

Specifically, Lysergic Acid, LSD (lysergic acid diethylamide), DMT (N-N-Dimethyltryptamine), peyote, mescaline, psilocyn or psilocybin, or any salts, derivatives, compounds, combinations or mixtures thereof and any substances which are chemically identical with such substances have been added to the list of dangerous drugs which may be used by or distributed to the general public only when prescribed by a licensed physician or other person authorized by law to prescribe or distribute such drugs.

In addition to expanding the list of drugs, the Legislature has broadened the penalties for violations of the dangerous drug law. Illegal use of dangerous drugs or possession without intent to sell such drugs is punishable by not more than one year imprisonment or $500 fine or both for the first offense. Penalties for a second or any subsequent offense are imprisonment of not more than two years and a fine of not less than $250 or more than $1,000 or both.

More severe penalties have been created for certain classes of violators. Thus, a "supplier" who is convicted of illegal possession, sale, furnishing or transportation of any dangerous drug may be imprisoned not more than five years or fined not more than $5,000 or both. A supplier is defined by the statute as any unauthorized person who manufactures, sells or gives any dangerous drug defined under this section for the use of any person for whom such drug has not been prescribed by a practitioner or who in any way delivers such contraband material to anyone he intends to induce to become a user.

In addition, punishment of not more than five years in prison or not more than $2,500 fine or both has been created for any person who intentionally advises, induces or encourages, directly or by any other means, another to commit a violation of the dangerous drug law.

The burden of proving that one should not be prosecuted under the "dangerous drug law" because of an exception, excuse, proviso or exemption contained in the law has been placed on the defendant. This means that if arrested and tried for a violation of the dangerous drug law, a physician or pharmacist who dispenses such drug would be required to prove that he fits within an exception.

Reference: Section 151.07, Wisconsin Statutes, 1967.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by the provisions of s. 200.26 and by no other law relating to insurance unless such law is referred to in s. 200.26 and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

* COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through May 1968.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in

its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

COMMENT: Reference Committee on Finances was authorized by the House of Delegates at May 1967 Annual Meeting.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

COMMENT: In October 1964, the House of Delegates authorized a special committee of ten members, one from each congressional district, to study redistricting.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being

made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of WISCONSIN MEDICAL JOURNAL).

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Health Information.
- A Commission on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

COMMENT: In May 1967, the House of Delegates changed the name of the Commission on Public Relations and Communications to the Commission on Health Information.

Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of five members, each of whom shall serve for a term of five years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. One member of each of these committees or commissions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two, three, four and five years, and thereafter for terms of five years each.

The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member.

SEC. 2. The Commission on Scientific Medicine shall consist of ten *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the WISCONSIN MEDICAL JOURNAL. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the scientific affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

COMMENT: Section 2, above, was amended in May 1964 by Resolution No. 30, which increased the number of appointed members from five to ten, and clarified the Commission's responsibility in that it shall be in charge of *scientific* affairs of the Journal.

SEC. 3. The Commission on Health Information shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Health Information shall study, make recommendations, and implement approved activities to improve the distri-

bution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven representatives from the membership at large, a representative from each Scientific Section created under Chapter XIII, Section 1, the president, president-elect, and the secretary. Representatives from the Scientific Sections shall be appointed by the president of the State Medical Society from a panel of three nominees submitted by each section, or in event of the failure of any section to submit nominees, the president may appoint a member from that specialty group. As nearly as possible the terms of one-third of the members representing the Scientific Sections shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three year terms. Representatives from the membership at large shall be appointed pursuant to Section 1 of this Chapter. The Commission may elect its own executive committee of five members.

The Commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

COMMENT: The Commission on Public Policy was completely reconstituted by the House of Delegates in May 1964, by Resolution No. 29.

SEC. 5. The Committee on Grievances is empowered to receive complaints concerning individual physicians or groups of physicians, and initiate investigations under standing rules which it may establish. It may review decisions of local grievance or arbitration committees on appeal therefrom, but nothing in this section shall be construed as inconsistent with the provisions of Chapter VI relating to responsibilities of the Council.

It shall be the purpose of the committee to endeavor to effect an equitable adjustment or understanding, and to resolve such differences between physicians, or between physician and patient or other complainant.

The efforts of the committee may be extended into areas of interprofessional conduct, the development of appropriate codes of interprofessional relations, and its initial responsibility shall be to the Council of the State Medical Society. It shall consist of nine members appointed for terms of three years, one-third of such terms to expire annually.

Consistent with the special purposes of this committee, all committee records and files pertaining to such matters shall be treated as confidential, shall not be open to inspection by other persons, shall not be released for any purpose and shall not be subject to subpoena.

COMMENT: In May 1967, the House of Delegates repealed Section 5 of Chapter VII and substituted the present wording.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

COMMENT: In October 1964, the House of Delegates concurred in recommendation that this Commission retain jurisdiction of both hospital relations and medical education.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The WISCONSIN MEDICAL JOURNAL shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of

the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the Wisconsin Medical Journal, and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

COMMENT: Section 6, above, was created by the Council as Resolution No. 27 and adopted by the House of Delegates in May 1964.

SEC. 7. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 8. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician whose principal practice is within the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of Constitution and Bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have practiced within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician's county society membership must be held in that county in which his principal practice is located. However, a physician living near a county line may hold his membership in that county most convenient for him to attend meetings, on permission of the component society in which county he maintains his principal place of practice.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society

may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 8, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1969–June 30, 1969

STATE DEPARTMENT OF PUBLIC INSTRUCTION

BUREAU FOR HANDICAPPED CHILDREN

MADISON, WISCONSIN 53702

Location	*Date*	*Location*	*Date*
Manitowoc	February 19, 20	Rhinelander	April 30, May 1
Stevens Point	March 5	Sheboygan	May 7, 8
Racine	March 12, 13	Chippewa Falls	May 21, 22
Ashland	March 19, 20	Superior	May 28
Kenosha	March 26, 27	Lancaster	June 4
Eau Claire	April 15, 16	Darlington	June 5
La Crosse	April 23, 24		

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examinations are sent to the referring physician following clinic.

REFERRAL FORMS: Referral forms may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for each clinic so when requesting same be sure to state how many forms are needed and for which clinic. It is important that we know well in advance the number desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 126 Langdon Street, Madison, Wisconsin 53702.

STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET

MADISON, WISCONSIN

The "Home" of the State Medical Society on the south shore of Lake Monona houses the Wisconsin Medical Journal, the Society's Blue Shield plan, general administrative offices, dining room, meeting room, and Council room. Nearly 200 committee and other meetings are held here annually.

Services to Members

Health Educational Activities

Voluntary Health Agency Contacts

Student Loans

Grievance Services

Museum of Medical Progress and Stovall Hall of Health

Executive Office Services

The Wisconsin Medical Journal

Life Insurance

Disability Income Protection

Wisconsin Work Week of Health

WPS Protection

WPS Charge Card Corp.

Open Panel Program under Workmen's Compensation

Postgraduate Education Programs

Physician Placement

Medicolegal Consultation

Public Relations

Legislative Representation

Governmental Agency Contacts

Medical Economic Advice

Members, State Medical Society of Wisconsin*

Adams:
Weihe, A. R.

Algoma:
Galang, L. L.
Hopkins, R. G.
March, J. F.
Papendick, D. E.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Arneson, O. N.
Byrne, W. R.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Schroeder, Daniel J., Jr.
Whitlark, F. L.

Antigo:
Beattie, B. W.
Blink, D. V.
Cromer, R. W.
Curran, W. P.
Fox, T. C.
Garbisch, F. H.
Garritty, J. E.
Lambert, J. W.
McKenna, J. E.
Moore, G. E.
Roth, E. J.

Appleton:
Anderson, J. G.
Belden, A. D.
Beglinger, H. F.
Bonner, J. N.
Bravick, D. D.
Brei, F. A.
Carlson, G. W.
Chandler, W. W.
Claypool, Blaine, Jr.
Cline, R. S.
Cunningham, P. M.
Curry, J. C.
Dafoe, W. A.
Danford, H. G.
DeCock, R. D.
Dungar, C. F.
Engstrom, D. P.
Erchul, J. W.
Evangelista, T. L.
Fenlon, C. E.
French, G. A.
Gallaher, D. M., Jr.
Giffin, W. S.
Gmeiner, J. E.
Graves, M. D.
Green, C. J.
Gross, H. T.
Grubb, W. B., Jr.
Hale, William H.
Hamel, H. H.
Harris, J. S.
Hauch, F. M.
Haza, B. J.
Hodges, P. C., Jr.
Huberty, F. J.
Kagen, M. S.
Keane, K. M.
Kennedy, R. O.
Kinde, R. R.
Kitzerow, E. B.
Konz, S. A.
Laird, J. W.
Landis, R. V.
Loescher, T. M.
Luther, T. W.
Manesis, J. G.
McCanna, P. R.
Meighan, P. P.
Meyers, C. L.
Mielke, E. F.
Mielke, J. E.
Miller, E. J.
Mueller, G. F., Jr.
Neidhold, C. D.
Nichols, G. P.
O'Boyle, R. F.
Petersen, G. J.
Plouff, L. T.
Querol, J. T.
Raney, E. H.
Rankin, F. J.
Reichle, R. I.
Richards, W. R.
Russell, J. H.
Ryan, T. A.
Santos, G. P.
Sargent, J. M.
Savage, G. W.
Slegrist, K. J.
Simenson, R. S.
Slette, D. R.
Sullivan, J. F.
Taylor, A. C.
Veum, J. S.
Warren, J. L.
Weissler, J. B.
Willlams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.
Zeiss, J. C.

Arcadia:
Chisholm, T. P.
Pesarillo, Servando

Argyle:
Hunter, R. E.

Ashland:
Bargholtz, W. E.
Grand, C. A.
Jauquet, J. M.
Koeller, A. A.
Kreher, J. E.
Larson, H. H.
Mercer, W. C.
Morrow, K. A.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Sneed, R. J.
Stanley, R. A.
Tucker, W. J.

Athens:
Regehr, E. H.

Augusta:
Moland, O. G.
Thieda, E. S.

Baldwin:
Grieben, L. R. J.
May, J. A.
Olson, C. A.
Sargeant, G. M.
Torkelson, L. B.

Bangor:
Ruppenthal, K. P.

Baraboo:
Edwards, A. C.
Hannan, K. D. L.
Hansel, R. G.
Holmen, G. J.
Huth, M. F.
Lewis, J. M.
Pearson, C. R.
Siebert, J. T.
Weston, E. L.

Barron:
MacMillan, D. G.
Strang, C. J.
Whaley, R. C.

Bear Creek:
Morneau, L. F.

Beaver Dam:
All, Masroor
Bayley, H. G., Jr.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Cook, R. S.
Corso, Xavier
Damon, R. A.
Davis, T. C., Jr.
Drescher, G. G.
Erickson, N. W.
Funcke, Wm. E.
Glunz, P. R.
Haessly, F. G.
Klomberg, G. H.
Kores, A. B.
Link, D. L.
Molina, Rudolfo
Qualls, C. L.
Richards, W. G.
Ritzenthaler, D. O.
Rowan, T.
Schulz, N. H.
Snook, W. H.
Szweda, J. A.
Taake, E. R.
Urbanek, R. E.
Vrabec, A. P.
Way, R. W.
Welsch, J. M.
Wohlwend, E. B.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Beloit:
Babb, J. L.
Baldwin, R. M.
Beltran, J. C.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Chancey, R. L.
Fitzgerald, W. M.
Flarity, T. H.
Frank, Jordan
Glesne, O. G.
Gold, K. I.
Gunderson, R. H.
Jones, E. T.
Kleppe, L. W.
Lakritz, L. W.
Lang, T. J.
Matthews, G. C.
Mauermann, W. J.
Pollard, W. H., Jr.
Pruett, W. A.
Qui, F. L.
Raube, H. A.
Sanderson, R. J.
Scholten, W. A., Jr.
Schwaegler, R. R.
Springberg, J. C.
Thayer, R. A.
Tuftee, A. O.
Twyman, A. H.
Wagelie, R. G.
Woodington, G. F.

Berlin:
Gimenez, A. R.
Koch, H. C.
Koch, J. C.
Osicka, S. R.
Schmidt, E. M.
Seward, L. J.
Slevers, D. J.

Big Bend:
Raschbacher, J. L.
Zarbock, F. M.

Birnamwood:
Damp, O. E.

Black River Falls:
Aprahamian, Charles
Daniells, A. S.
Holder, R. L.
Krohn, Eugene
Krohn, Robert
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Bloomer:
Asplund, M. W.
Clauson, C. T.
Murphy, P. W.

Bloomington:
Edwards, P. K.

Bonduel:
Grover, W. W., Jr.
Stuff, Patricia J.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Mueller, C. E.
Randall, E. M.

Brandon:
Adams, H. G.

Brillion:
DeArteaga, Julio

Brodhead:
Stuessy, M. W.

Brookfield:
Bemis, E. L.
Brown, D. H.
Cassidy, G. E.
Deeds, E. C.
Fick, K. R.
Fitzpatrick, P. J.
Franzen, L. D.
Gager, W. E.
Hart, T. N.
Jennison, M. R.
Jurisic, Anthony
Lipscomb, C. R.
Luedke, D. M.
Mann, D. H.
Meves, T. F.
Nemcek, A. A.
Pavlic, R. S.
Restrepo, Roberto
Roth, D. A.
Sewell, R. H.
Stoklos, Michael
Teresi, J. L.
Toepfer, R. A.
Viel, R. S.
Werts, K. G.
Wood, D. L.
Wright, I. V.

Brown Deer:
Kritter, F. J.

Brownsville:
Friedrich, L. E.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Baker, D. J.
Batsleer, R. L.
Erickson, L. W.
Gander, E. P.
Granzeau, H. W.
Krismer, G. J.
McNeel, Laird
Sroka, Wm. C.
Van Liere, J. D.
Wheaton, R. C.

Butternut:
Boldt, R. E.

Cadott:
Bowe, C. T.
Haines, B. J.
Zenner, C. E.

Cambridge:
Amundson, K. K.
Nemec, George, Jr.

Campbellsport:
Hoffmann, L. A.

* As of Dec. 31, 1968.

Casco:
Kerscher, E. J.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Huckaby, A. L.
Hurth, O. W.
Katz, H. J.
Kippenhan, J. E.
Misch, Allen

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.
Bannister, F. M.
Pierpont, D. B.

Chilton:
Humke, K. R.
Klein, M. H.
Knauf, J. W.

Chippewa Falls:
Brown, F. J.
Carlson, S. D.
Danl, D. A.
Graber, Rex E.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Kemper, C. A.
Picotte, L. W.
Rahn, B. F.
Sazama, F. B.
Sazama, J. J.
Windeck, J. L.

Clear Lake:
Campbell, L. A., Jr.

Clinton:
Mejia, G. B.
Pili D. B., Jr.
Thomas, W. O.

Clintonville:
Arnold, W. G.
Bate, L. C.
Caskey, H. S.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Koch, James W.
Pfefferkorn, E. D.

Coleman:
Graner, L. H.

Colfax:
Felland, O. M.

Colgate:
Domann, W. G.
Stein, R. W.

Columbus:
Cheli, C. F.
Poser, J. F.
Poser, R. F.
Shearer, C. E.

Cornell:
Hendrickson, R. L.

Cottage Grove:
Vogt, G. H.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Crivitz:
Settlage, H. A.

Cross Plains:
Lappley, W. F.

Cuba City:
King, C. S.
Stone, M. M.
Taylor, H. W., Jr.

Cudahy:
Armagan, Senekerim
Chelius, C. J.
Cornell, J. W.
Fine, J. M.
Fons, J. W., Jr.
Frederick, J. J.
Homsey, J. J.
Jerofke, A. M.
Kash, S. H.
Lando, D. H., Jr.
Landsberg, Manfred
Latorraca, Rocco
Marcich, Z. P.
Nuyda, D.
Oddis, N. A.
Potos, W. B.
Tabet, R. C.
Vitulli, V. N.

Cumberland:
Anderson, R. M.
Jirsa, H. O.
Lund, R. E.

Darlington:
McGreane, N. A.
Olson, Lyle L.
Ruf, D. F.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.

Delavan:
Galgano, R. S.
Martin, J. E., Jr.
O'Keefe, F. L.
Roesler, M. J.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Hering, G. V.
Michna, C. T.

De Pere:
Levitas, I. E.
Mackey, J. P.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

Dodgeville:
Buckner, H. M.
Downs, D. R.
Hamilton, W. P.
Rasmussen, N. G.

Dousman:
Pecarski, Miodrag

Durand:
Bryant, R. J.
Myers, M. E.
Springer, J. P.

Eagle River:
Colgan, J. J.
Jacobson, L. L.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Flynn, R. T., Jr.
Kohn, Louis

Eau Claire:
Aitken, H M.
Bates, P. J.
Beckfield, W. J.
Beebe, G. W.
Bjurstrom, R. O.
Brousseau, E. R.
Brown, J R.
Brown, R. C.
Buckley, R. A.
Cameron, W. G.
Dibble, J. B.
Edson, J. D.
Fink, R. J.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Giffen, G. G.
Gonlag, Harry
Griffith, D. R.
Haag, A. F.
Halgrimson, K. W.
Henke, F. W.
Henke, S. L.
Hilker, A. W.
Hill, E. F.
Hoff, D. E.
Hudson, R. F.
Huston, H. C.
Ihle, C. M.
Kass, R. M.
Kelley, W. M.
Kennedy, R. L.
Kilkenny, T. E.
Klein, A. J.
Larkin, W. B.
Lorenz, A. A.
Lotz, R. M.
Manz, W. R.
Martins, J. K.
Mautz, W. T.
McAfee, G. D.
Midelfart, Peter A. H.
Miller, D. F.
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Niver, E. O.
Ostenso, R. S.
Owen, G. E.
Paulson, W. O.
Raymond, L. A.
Richards, R. R.
Schulz, Emil
Sorensen, H. E.
Spelbring, P. G.
Sperry, V. A.
Stewart, K. E.
Strand, R. C.
Thimke, H. E.
Tobin, J. M.
Wahl, G. E.
Walter, K. E.
Walter, Wm.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B

Edgar:
Schulz, H. A.

Edgerton:
Boulet, W. J.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Pavlik, K. K.
Shearer, T. M.
Sumner, W. C.

Elcho:
Dailey, D. W.

Elkhart Lake:
Heiden, H. H.
Martineau, J. E.

Elkhorn:
Bill, K. C.
Helmbrecht, M. G.
Mol, H. R.
Petersen, R. D.
Rawlins, J. A.
Rogers, R. J.
Schrock, J. B., Jr.
Sorenson, E. D.
Wade, Chester

Ellsworth:
Jonas, E. R.

Elm Grove:
Barrock, J. J.
Bauer, C. A.
Bauer, K. T.
Carey, Larry
DeVault, M. L.
DiMiceli, Ettore, Jr.
Dudenhoefer, P. A.
Erwin, C. J. R.
Erwin, C. P.
Grade, J. O.
Hanauer, M. M.
Headlee, C. R.
Hepperla, R. L
Klingbeil, R. E.
Manhart, R. A.
Mateicka, W. E.
Millington, P. E.
Myers, S. C.
O'Connor, T. M.
Redlin, R. R.
Rouman, W. C.
Settima, A. L.
Shockley, B. F., Jr
Sinclair, E. P.
Van Gilder, J. H.
Wisniewski, J. H.
Zurheide, H. J.

Elmwood:
Springer, F. A.

Elroy:
Balder, R. B., Jr.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.
Stupek W. S.

Fond du Lac:
Becker, N. O.
Benneyan, R. N.
Bissegger, Arnold
Borsack, K. K
Carlovsky, R. E.
Cerny, F. J.
Charles, J. E.
Cullen, R. E.
Devine, J. C.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Huebner, J. S.
Hutter, A. M.
Jones, L. E.
Keenan, L. J.
Kendell, W. G.
Klef, H. J.
Koll, J. H.
Lawrence, D. L.
Leonard, C. W.
Llewen, B. E.
Longstreth, C. R.
Mauthe, Howard
McBride, F. F.
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Meisinger, G. F.
Myers, W. E.
Pallin, Josephine N.
Parrish, J. G., Jr.
Pawsat, E. H.
Peters, John
Peterson, C. R.
Rupple, J. H.
Schlichting, J. E.
Schroeder, R. W.
Shahrokh, D. K.
Sharpe, H. R., Jr.
Sisk, J. A.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.

Theis, E. H.
Theisen, S. A.
Thomas, H. R., Jr.
Treffert, D. A.
Twohig, D. J., Jr.
Vetter, E. W.
Vrtiiek, M. R.
Waffle, R. L.
Waidschmidt, W. J.
Weber, D. R.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Aufderhaar, H. W.
Bates, D. E.
Beran, F. V.
Gueldner, L. H.
Handeyside, R. G.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Russell, J. C.
Sholtes, C. A.
Vognar, S. F.

Fox Point:
Peters, L. M.
Silberman, Jack
Thompson, L. H.

Franksville:
Gass, H. I.

Frederic:
Andrews, W. C.
Fischer, W. A.
Schwab, D. F.

Fremont:
Gloss, A. J.

Friendship:
Janssen, M. L.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker, Cornelis

Germantown:
Lastrilla, R. S.

Glendale:
Brazy, R. R.
Mendeloff, Elton
Wegmann, G. H.

Glenwood City:
Limberg, A. W.
Limberg, P. W.

Grafton:
Fueredl, Adam
Pelant, K. F.
Seldi, J. A.

Grantsburg:
Hartzell, R. L.
Hartzler, P. L.

Green Bay:
Adamski, V. D.
Andrew, R. C.
Angus, D. C.
Austin, S. D.
Belson, M. J.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Boersma, J. J.
Bramschreiber, J. L.
Brault, R. G.
Breister, K. A.
Brusky, A. H.
Brusky, E. S.
Caffrey, J. F.
Clark, E. V., Jr.
Cook, F. D.
Crawford, C. W.
Danaher, H. H.
Dega, F. J.
Denys, G. F.
Dettmann, J. E.
Donarski, D. P.
Draheim, J. H.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Falk, M. J.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Gallagher, D. J.
Gehring, J. V.
Goeiz, J. R.
Grace, J. B.
Green, J. R.
Griggs, S. L.
Gruesen, R. A.
Guthrie, J. M., Jr.
Haines, A. W.
Hammes, D. A.
Hart, L. E.
Heitzman, H. H.
Hitch, O. M.
Hoegemeier, H. W.
Hoops, H. J., Jr.
Jensen, R. E.
Johnston, R. E.
Kaftan, G. R.
Kaufman, J. E.
Kenny, J. A.
Killeen, E. R.
Kllins, J. A.
Kuehl, F. O.
Kulkoski, Bernard
Kullerstrand, D. S.
Leicht, T. R.
Le Mieux, G. E.
Lynn, T. E.
MacMullen, Wallace, II
Marnocha, J. R.
Martin, J. E.
McCarey, A. J.
McCormick, R. A.
McGuire, G. E.
McKenna, D. H.
McManus, J. T.
McNeal, W. E.
Mickie, K. C.
Miller, L. C.
Mills, J. M.
Milson, B. I.
Milson, Louis
Milson, S. E.
Mokrohisky, J. F.
Myers, R. L.
Nadeau, E. G.
Nadeau, E. G., Jr.
Nellen, J. W.
Neu, V. F.
Nicolaus, W. H.
Nishioka, Hiro
Ottum, J. A.
Oudenhoven, R. C.
Philipp, L. D.
Rahr, H. C.
Richardson, B. L.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Sandmire, H. F.
Schlbly, W. J.
Schmidt, R. T.
Schneider, W. F.
Schumacher, J. P.
Sehring, F. G.
Shea, D. W.
Sherwood, D. L.
Shinners, G. M.
Sipes, D. R.
Silghtam, P. E.
Smith, C. C.
Stauff, G. R.
Stiennon, O. A.
Stoehr, B. J.
Stoll, W. M.
Sullivan, Donel
Terner, E. A.
Theiler, G. J., Jr.
Thompson, L. L.
Troup, R. H.
Troup, R. L.
Troup, W. J.
Urban, Frank
Utrie, J. W.
Von Heimburg, Roger
Wallerius, J. F.
Wochos, R. G.
Zucker, K. L.

Greendale:
Brown, R. J.
Gabriel, R. P.
Kottke, M. A.
Kuglitsch, E. F.
Taugher, P. J.
Wengelewski, H. B.
Westley, William, Jr.

Greenfield:
Mohanty, R. K.
Walker, T. F.

Green Lake:
Barbour, J. H.
Leininger, A. T.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Altstadt, J. F.
Bottum, M. W.
Clemence, J. A.
Czajka, J. J.
Damiano, N. F.
Everts, E. L.
Gillespie, C. J.
Grosshandler, S. L.
Jachowicz, R. B.
La Susa, T. J.
Pierce, D. F.
Sortor, R. F.
Wolf, R. C.

Hartford:
Aigiers, J. L.
Arrambide, George
Hoffmann, J. G.
Hoffmann, W. C.
Kern, T. J.
Mally, M. J.
Monroe, M. E.
Nickels, R. J.
Quackenbush, E. C.
Quandt, V. V.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hawthorne:
Farias, O. A.

Hayward:
Baertsch, L. M.
Callaghan, D. H.
D'Elia, Rudolph
Rosmann, H. K.
Sahs, M. H.
Stang, H. M.

Hazel Green:
Farbstein, M. E.
Klein, G. J.

Hilbert:
Pinney, J. C.

Hillsboro:
Boston, T. E.
Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, F. A.

Hortonville:
Bergwall, J. G.
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Timp, L. F.

Hurley:
Martinetti, D. J.

Hustisford:
Goetsch, O. F
Davasligil, Halil

Independence:
Meyer, C. F.

Iola:
Hollero, N. J.

Jackson:
Albrecht, J. E.

Janesville:
Apfelbach, G. L.
Baker, C. S.
Betlach, Dorothy W.
Betlach, Eugene H.
Bostian, K. E.
Chicks, C. O.
Clark, W. T.
Dodge, R. K.
Donkie, M. J.
Fitzgerald, G. P.
Frechette, F. M.
Gilbertsen, C. R.
Gredler, G. P.
Gutmann, G. E.
Hansen, T. R.
Hartlaub, E. S.
Healy, W. G.
Holland, R. A.
Job, E. J.
Karzei, R. P.
Knepel, Donald
Koch, V. W.
Kochell, R. L.
Kronquist, G. E.
Lakritz, Amrum
Levin, Harland
Llewellyn, M. B.
McNichols, E. F
McSweeny, A. J.
Nash, C. B.
Neeno, Katsumi
Nienhuis, H. D.
Nolta, R. T.
Nuzum, T. O.
O'Brien, J. N.
Odland, P. K.
Otterholt, E. R.
Overton, R. S.
Pember, J. F.
Pennepacker, J. S.
Peters, E. E.
Peterson, Geo. H.
Plautz, A. C., Jr.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Russo, F. R.
Sabado, E. F.
Sargeant, T. S.
Schroder, John R.
Schroeder, Jack D.
Shoil, P. R.
Smith, D. A.
Snodgrass, H. M.
Thomas, G. L.
Tordoff, J. J.
Tregoning, P. C.
Vogel, T. L.

Jefferson:
Busse, A. A.
Quandt, C. E.
Quandt, R. W.
Siedenburg, Richard

Johnson Creek:
Wendt, F. A.

Juneau:
Heath, H. J.

Kaukauna:
Bachhuber, A. E.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.
Sklbba, J. P.
Wolfmeyer, W. W.

Kenosha:

Ambro, P. J.
Armstrong, G. F.
Ashley, R. W.
Baicjunas, Vitoldas
Barnes, E. H., III
Barreto, R. S.
Bilak, R.
Bjork, H. A.
Bode, M. J.
Bonell, B. T.
Burhani, A. W.
Burnett, R. G.
Capelli, P. A.
Conzelman, D. R.
Cozine, W. I.
Creighton, L. H.
Creswell, C. M.
Cruz, N. R.
Davis, D. W.
DeFazio, S. F.
Donnell, W. S.
Duncan, J. T., Jr.
Fai, L. L.
Ferwerda, J. R.
Fraser, W. E.
Garren, J. T., Jr.
Goldstein, D. N.
Gomilla, S. G.
Graves, J. P.
Haifon, Nesim
Hauschild, W. A.
Heck, J. A.
Hill, B. Spalding
Holt, S. H.
Horsley, D. B.
Kent, L. T.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Meeter, U. L.
Mercado, R. C.
Miller, David
Millikin, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pamukcu, F.
Pamukcu, Afet
Pearson, J. B.
Pechous, C. E
Pechous, C. E., Jr.
Peterson, C. E.
Powell, R. A.
Rafferty, H. P.
Rattan, W. C.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Ruffo, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Swift, W. J.
Turner, Lewis, III
Wadina, G. S.
Wagner, H. B.
Weber, G. R.
Welsch, R. G.
Whetstone, O. H.
Williams, F. C., Jr.
Wilson, R. E.
Wood, Fredrick, Jr.

Kewaskum:

Edwards, R. G.

Kewaunee:

Lanier, A. S.
Lanier, Patricia F.
Nesemann, R. M.
Wits, E. W.

Kiel:

Nauth, D. F.
Theiler, A. C.
Twohig, G. J.

Kimberly:

Gage, Ralph S.
Knoedler, W. H.

King:

McGinnis, H. J.

Kohler:

Forkner, W. A.
Gascoigne, C. C.
Rowe, D. M.

La Crosse:

Aiken, R. E.
Alvarez, Ubaldo
Anderson, E. M.
Anderson, N. P.
Anderson, P. D.
Bach, A. C.
Belber, C. J.
Brailey, A. G., Jr.
Britt, A. G.
Buchman, D. M.
Carlsson, E. S.
Cejpek, K. O.
Clemons, J. E.
Cook, A. A.
Copps, S. C.
Corser, D. H.
Da Costa, W. C.
Dalton, R. M.
Dietz, P. C.
Durst, J. B.
Egan, G. J., Jr.
Ellenz, G. B.
Ernst, F. W.
Felion, P. L.
Fisher, A. L.
Flynn, R. E.
Fox, J. C.
Gallagher, F. J.
Gallagher, W. B.
Getz, Kaare
Gilbert, R. L.
Goodnough, D. E.
Green, R. M.
Guernsey, Gretchen
Gundersen, A. E.
Gundersen, A. H.
Gundersen, A. L.
Gundersen, Cameron
Gundersen, G. A., Jr.
Gundersen, Gunnar
Gundersen, J. H.
Gundersen, S. B., Jr.
Gundersen, T. E.
Haidinyak, A. L.
Haug, S. L.
Hayden, J. W.
Hellesen, P. J.
Hickey, A. W.
Howard, R. S.
Hulick, P. V.
Janis, J. F.
Joseph, L. G.
Kalfayan, Bernard
Keimowitz, R. M.
Leiby, R. W., Jr.
Link, C. E.
MacEwen, A. R.
Mahairas, G. H.
Mansheim, B. J.
McGarty, M. A.
McKee, D. C.
McMahon, R. E.
McNamara, T. B.
Meis, P. J.
Midelfort, C. F.
Miner, E. B.
Morgan, W. A.
Murphy, G. B., Jr.
Murphy, J. T.
Newcomer, K. L.
Nickel, F. A.
O'Leary, Wm. J., Jr.
O'Meara, M. T.
Orman, E. S.
Overholt, E. L.
Perry, E. L.
Phillips, P. W.
Pribek, R. A.
Ramlow, R. W.
Rasmus, R. B.
Richter, J. R.
Satory, J. J.
Scheurich, Mary B.
Schmidt, C. F.
Schmidt, L. R.
Schneeberger, E. J.
Schuldes, R. E.
Sevenants, J. J.
Shealy, C. N.
Shields, J. C.
Simones, J. J.
Skemp, C. A.
Skemp, F. C.
Skemp, G. E.
Skemp, J. J.
Skemp, J. T.
Skemp, S. J.
Slungaard, Roiv
Smith, Martin J.
Taebel, D. W.
Tankersley, J. C.
Thompkins, D. G.
Uhrich, G. I.
Van Susteren, J. A.
Watunya, M. J.
Weeth, J. B.
Whiteway, R. E.
Wolf, F. H.
Yutuc, W. R.

Ladysmith:

Bauer, W. B. A. J.
Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

La Farge:

Lee, Connie

Lake Geneva:

Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.
Rauch, A. M.

Lake Mills:

Eck, G. E.
Effenhauser, Manfred
Leering, Hendrik
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.

Lancaster:

Bauman, K. L.
Becher, L. E.
Carey, H. W.
Hillery, G. C.
Houghton, E. M.
McCay, Sophia

Land O' Lakes

Eickhoff, E. C.

Laona:

Castaldo, E. F.
Ovitz, E. G.

Lena:

Rose, J. F.

Little Chute:

Buchanan, K. E.
Van Lieshout, F. X.

Lodi:

Irwin, W. G.

Loyal:

Habie, A. P.

Luxemburg:

Majeski, H. E.

Madison:

Aageson, C. W.
Abroms, G. M.
Aguilar-Sincaban, V. M.
Ainslie, R. B.
Albright, E. C.
Albright, J. G.
Allen, J. R.
Allen, J. C.
Allen, Mauery
Allin, R. N.
Anderson, A. D.
Anderson, J. L.
Anderson, Jeanne
Andrew, R. B.
Andringa, C. L.
Angevine, D. M.
Ansfield, F. J
Ansusinha, Tamnit
Ashman, H. C.
Backs, M. F.
Backwinkel, K. D.
Bamforth, Betty J.
Barnes, H. P. G.
Barta, R. A., Jr.
Bartlett, W. H.
Batson, J. F.
Bauman, B. J.
Baumblatt, M. J.
Beck, J. P.
Becker, R. M.
Bellman, R. L.
Belknap, E. L., Jr.
Benish, G. A.
Bennett, Maxine
Berg, Mary C.
Berger, J. V., Jr.
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Bernhardt, L. C.
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Carter, H. M.
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Chosy, L. W.
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Emanuel, D. A.
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Fletcher, F. W.
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Hansen, R. L.
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Ousley, J. L.
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Rice, T. J.
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Schorr, W. F.
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Pratt, G. N., Jr.
Reilly, G. D.
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Weber, M. L.
Weil, H. R.
Weingarten, Maxwell
Weinshel, L. R.
Weisel, Wilson
Weisenthal, C. L.
Weisfeld, S. G.
Weisfeldt, S. C.
Weller, R. R.
Wells, Marvin
Welsh, E. C.
Wepfer, J. F.
Werner, D. J.
Whalen, G. E., Jr.
Wiegmann, O. A.
Wild, J. P.
Wilets, J. B.
Williams, DeLore
Willson, D. M.
Winnik, D. E.
Wirthwein, C. L.
Wisniewski, P. P. Jr.
Wiviott, Wilbert
Wolf, L. P.
Wolfe, C. W.
Woloschek, W. J.
Wolter, S. H.
Wong, V. J.
Woodward, G. S
Worman, L. W.
Worsencraft, H. M.
Wunsch, C. A.
Wyman, J. F.
Wynn, S. K.
Yatso, M. G.
Yellick, C. W.
Youker, J E.
Young, Carol E.
Young, H. C.
Young, W. N.
Yount, L. J.
Zarem, N. L.
Zastrow, R. C.
Zautcke, A. B., Jr.
Zellmer, J. H.
Zeps, A. A.
Ziehl, F. L.
Zillmer, Helen J.
Zimmermann, B. M.
Zuege, R. C.
Zupnik, G. R.

Mineral Point:
Hamlin, W. D.
Hohler, E. J.

Minocqua:
Ashe, H. S.
Huber, G. W.
Smith, R. L.

Mishicot:
Nilles, J. E.

Mondovi:
Johnson, D. B.
Mills, E. G.
Sharp, D. S.
Wright, W. E.

Monroe:
Barry, G. R.
Baumann, R. R.
Bear, N. E.
Brunkow, B. H.
Chandler, Arthur, Jr.
Eckstam, E. E.
Fencil, W. J.
Fuller, J. R.
Harned, R. K.
Hassler, R. E.
Hein, W. E.
Herzberger, E. E.
Irvin, J. M.
Jew, S. Q.
Kamstra, E.
Kindschi, L. G.
Maddix, B. L.
Miller, C. O.
Mings, D. E.
Murray, J. F.
Najat, Hushang
Olson, M. J.
Rush, B. M.
Santiago, F. S.
Springer, D. W.
Staab, W. J., Jr.
Stiles, F. C.
Stormont, J. R.
Villacrez, J. A.
Watt, T. L.
Weeks, J. H.
Weir, J. R.
Wichser, R. F.
Witte, K. B.
Zach, R. G.
Zupanc, E. A.

Montello:
Inman, R. F.

Montfort:
Breier, H. P.

Mosinee:
Roberts, R. R.

Mount Calvary:
Miller, J. F.

Mount Horeb:
Morrison, M. T.

Mukwonago:
Kern, E. E.
Rosenkranz, W. E.
Zwisler, E. E.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Kelm, G. J.

Neenah:
Anderson, G. R.
Arndt, G. W., Sr.
Atassi, S. A.
Beatty, S. R.
Brown, R. C.
Colgan, H. J.
Dedmon, R. E.
Dettmann, F. G.
Douglas, R. F.
Flaherty, T. T.
Geldner, Barbara
Geldner, M. M.
Gohdes, P. N.
Graham, A. P.
Gursoy, E. Y.
Hardie, G. H.
Haselow, J. R.
Hoggatt, J. E.
Kennedy, W. F.
Kirchgeorg, Clemens
McAndrew, J. B.
McCutcheon, Malcolm
McGloin, J. J.
McGloin, Mary T.
Pansch, F. N.
Petersen, G. W.
Potter, G. L.
Regan, D. M.
Ryan, D. J.
Schaefer, Frederick
Schrang, E. A.
Schwab, R. L
Sickles, W. F.
Smith, F. H.
Springer, V. G.
Stelter, G. P.
Suechting, R. L
Talbot, A. E.
Varberg, W. R.
Zimmerman, D. E.

Neillsville:
Capadi, N. R.
Comstock, Elizabeth
Gungor, B. O.
Manz, K. F.
Ozturk, C. H.
Rosekrans, M. C.
Rosekrans, Sarah D.
Thompson, T. N., Jr.

Nekoosa:
Pfeiffer, L. R.
Thompson, J. E.

New Berlin:
Gilbert, Francis
Komar, R. R.
Schofield, Raymond
Selle, F. S.
Varma, S. D.

New Franken:
Looze, J. A.

New Glarus:
Marty, P. H.

New Holstein:
Engel, A. C.
Larme, F P.
Schultz, W. F.

New Lisbon:
Parong T. M.
Weston, C. L.

New London:
Monsted, J. W.
Schmallenberg, H. C.
Weber, J. W.

New Richmond:
Armstrong, J. H.
Craig, J. L.
Davis, R. R.
Drury, E. M.
Epley, O H.
Melby, M. A.
Weisbrod, L. W.

Niagara:
Maginn, Richard J.
McCormack, E. A.

Norwalk:
Allen, J. S.

Oconomowoc:
Bruner, A. M.
Claude, J. L.
Driscoll, L. J.
Epperson, D. P.
Frank, E. B.
Goral, T. J.
James, W. D.
Lameka, Peter
Matt, J. R.
Miller, G. D.
Nammacher, T. H.
Rogers, A. F.
Schroeder, T. A.
Schuele, D. T.
Schumacher, B. J.
Theobald, P. B.
Weir, E. F.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

Oconto:
Heinen, R. D.
Honish, John S.
Rogers, R. J.
Zantow, F. E.

Oconto Falls:
Culver, J. R.
Siefert, C. E
Strebe, K. L.
Theisen, J. K.

Omro:
Peck, D. D.
Schoenbechler, L. J.

Oregon:
Dukerschein, F. N.
Johnson, E. S.
Kellogg, L. S.

Orfordville:
McNair, E. R.

Osceola:
Inyart, J. R.
Simenstad, J. O.
Simenstad, L. O.

Oshkosh:
Apell, M. G.
Becker, D. B., Jr.
Behnke, C. H.
Bitter, R. H.
Bowerman, C. I
Clark, W. E.
Crawford, W. A.
Cummings, E F.
Danforth, H. J.
Emrich, P. S.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Hitselberger, J. F.
Hughes, J. B.
Isom, R. G.
Kivlin, T. M.
Koehler, A. G.
Kuhn, R. V.
Leibenson, S. J.
Leschke, John A.
Lyons, C. R.
McKenzie, J. R.
Meilicke, C. A.
Meli, J. V.
Monday, Harvey
Neubecker R. D.
Payne, J. C.
Petersik, J. T.
Roberts, R. W.
Romberg, H. A.
Scheuermann, N. M.
Seay, M. J.
Steen, M. H.
Stone, L. H.
Wagner, R. F.
Wagner, W. A.
Williams, E. B.
Winter, E. F.
Wolfgram, R. C

Wright, E. N.
Zmolek, E. J.

Osseo:
Garber, B. G.
Garber, R. D.
Leasum, R. N., Jr.

Owen:
Phillips, T. A.

Pardeeville:
Westcott, T. S.

Park Falls:
Enzinger, Josef
Eyvindsson, E. T.
Hanek, R. D.
Leahy, J. D.
Murphy, J. L.

Pell Lake:
Roenau, Elly A.

Peshtigo:
Barrette, Antoine

Phelps:
Wolcott, R. R.

Phillips:
Niebauer, W. E.
Rens, J. L.

Plain:
Galarnyk, I. A.

Platteville:
Andrew, C. H.
Gurkow, H. J.
Moffett, J. L.
Nuland, S. J.
Steidinger, C. L.
Stuessy, M. F.

Plum City:
Docter, C. W.
Docter, J. C.

Plymouth:
Alvarez, R. J.
Brickbauer, A. J.
Dietsch, L. C.
Evers, R. H.
Steffan, L. J.
Weisse, H. A.

Portage:
Binnie, Helen A.
Bronson, F. H.
Cooney, R. T.
Grose, C. D.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.
Villavicencio, C. A.

Port Edwards:
Glenn, E. C.

Port Washington:
Bach, M. J
Barr, A. H.
Henkle, R. F.
Kauth, C. P.
Savage, G. F.
Wallestad, P. W.
Walsh, John F.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Garrity, M. S.
Love, R. G.
Satter, O. E.
Wong, J. R.

Prairie du Sac:
Bishop, P. R.
Carlson, H. P.
Zauft, G. W.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.

Pulaski:
Shippy, V. J.

Racine:
Ageloff, Harry
Albino, J. M.
Alexander, A. C.
Bacon, G. A.
Barina, H. J.
Baumblatt, D. P.
Baylon, V. A.
Bein, Robert
Bennett, W. H.
Bliwas, Arnold
Brewer, G. W.
Brooks, J. C.
Bruton, J. T.
Buckley, W. E.
Burch, V. J.
Burke, Donald
Christensen, F. C.
Christenson, C. W.
Coffey, B. T.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
Currie, R. E
DeGroot, H. E.
Dorman, T. W.
Englander, S. M.
Faber, S. J.
Fazen, L. E., Jr.
Ferrazzano, G. P.
Floch, L. J.
Fogle, R. J.
Foreman, J. W.
Fralich, J. C.
Gardetto, P. A.
Geenen, J. E.
Gehring, C. A.
Gerol, A. Y.
Gillett, G. N.
Goldstein, F. P
Graf, A. E.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Hammes, J. R.
Harris, W. C.
Henken, W. F.
Herrmann, A. A.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Jacobsen, A. J.
Jamieson, J. G.
Johnson, P. S.
Kaarakka, O. F.
Keland, H. B.
Kolmeier, K. H
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Lauerman, E. P.
Lehner, R. H.
Leitschuh, R. B.
Little, W. J., Jr.
MacVicar, E. L., Jr.
Maden, W. J.
Martinez, Enrique
Martinez, M. E.
Martinez-Larre, M.
Mayer, R. J.
McHale, J. A.
Miller, H. C.
Miller, P. L.
Miller, V. M.
Miller, W. C.
Minton, Richard
Nelson, M. W.
Newman, C. R.
Nickelsen, J. R.
Oberdorfer, C. E.
Olson, E. S.
Parker, M. G.
Patton, C. H.
Petersen, J. J. G.
Pinkus, W. H.
Pope, F. W.
Postorino, J. D
Rafiullah, Mahammed
Reyes, J. E., Jr.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Schatz, W. R.
Scheible, F. J.
Scheller, R. F.
Schenkenberg, Grace E.
Schleper, A. J.
Schroeder, H. T.
Schuster, Myron
Shack, J. B.
Short, H. W.
Skow, G. D.
Skupniewicz, R. E.
Smith, L. W.
Smollen, W. J.
Smullen, G. H.
Steffen, Elizabeth A.
Stika, E. A.
Tomklewicz, R. E.
Tsuchina, Goro
von Jarchow, B. L.
Veranth, J. J.
Williamson, W. H.
Yasatan, N. H.

Randolph:
Horvath, D. C.

Random Lake:
Russell, J. A.

Reedsburg:
Booher, J. A.
Hanko, J. E.
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Simeon, R. G.
Stadel, E. V.

Rhinelander:
Bump, W. S.
Cline, Frances A.
Eggman, L. D.
Haug, Thomas M.
Johnson, A. G.
Litton, E. W.
Litton, M. A.
Nevin, Ismail Nik
Osborne, R. R.
Pratt, G. F.
Pulido, E. D.
Rosemeyer, O. G.
Schiek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Rice Lake:
Cotts, L. R.
Eidsmoe, N A
Gillespie, M. E.
Henningsen, John
Hoyer, J. K.
Kristensen, L. A.
Kundel, R. R.
Maser, J. F.
Rydell, O. E.
Rydell, W. B.

Richfield:
Zintek, A. R.

Richland Center:
Edwards, R. W.
Edwards, W. C.
Glise, Roy C., Jr.
Housner, R. E.
Kelertas, J. H.
Meyer, K. H.
Parke, George, Jr.
Pippin, L. M.
Spear, Jack
Taft, D. J.
Tydrich, J. J.

Ripon:
Bachus, A. C.
Dittmer, O. A.
Johnson, J. M.
Lofdahl, S., Jr.
Pelton, R. S.
Schuler, W. H.

River Falls:
Cicero, J. J.
Dohnalek, D. W.
Grassl, F. O.
Hammer, R. M.
Haskins, P. S.
Orlow, W. O.
Witt, D. L.

Rosholt:
Benn, V. A.

St. Croix Falls:
Ericksen, D. M.
Koepke, G. H.
Lagus, A. T.
Nelson, L. K.
Olson, L. L.
Peterson, E. H
Riegel, F. B.
Riegel, J. A.
Wegner, M. E.

St. Nazianz:
Foley, M. E.

Sauk City:
Kraus, E. T. F.
Walsh, T. W.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sleb, L. H.

Shawano:
Albright, J. J.
Arvold, D. S.
Bergmann, F. T.
Cantwell, A. A.
Cantwell, R. C.
Coan, W. A.
Jeffries, Donald A.
Logemann, R. L.
Schulz, D. W.
Sebesta, A. J
Wessels, D. H.

Sheboygan:
Ashby, A. O.
Bassewitz, P. P.
Batzner, D. J.
Braun, N. P.
Bringe, J. W.
Cinelis, Ann A.
Dick, H. J.
Eckardt, B. F.
Gore, D. R.
Graf, C. A.
Gruenewald, Ludwig
Heinz, H. N.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Hoon, J. R.
Houfek, E. E.
Huibregtse, W. G.
Jaeck, J. L.
Jochimsen, E. H.
Johnson, R. C.
Jumes, M. G.
Keller, R. A.
Kovacic, J. F.
Malewiski, L. J.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Michael, J. D.
Moir, Jane M.
Moir, W. W.
Mueller, H. A.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.

Pauly, L. F.
Pauly, R. C.
Pointer, R. W.
Quinn, G. A.
Rammer, M. A., Jr.
Reinemann, J. M.
Schott, E. G.
Schroeder, I. L.
Sclarra, P. A.
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Stewart, O. K.
Tasche, J. A.
Tasche, L. W.
Tompsett, A. C., Jr.
Van Driest, J. J.
Weber, C. J.
Windsor, R. B.
Wood, R. A.

Sheboygan Falls:
Hansen, H. J.
Weygandt, J. L.

Shell Lake:
Flogstad, D. L.
Moen, D. V.
Welter, D. J.

Shiocton:
La Croix, G. M.

Shorewood:
Vlazny, F. J.

Silver Lake:
De Witt, C. A.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Adali, I. S.
Crigler, R. R.
Flaherty, G. S.
Grimm, J. J.
McFadden, Wayne
Murphy, G. V.
Pizer, J. A.
Roob, D. M.
Schwartz, H M.
Spencer, G. N.
Theisen, C. E.
Turgal, Valerio

Sparta:
Albrecht, P. G.
Beebe, D. C.
Brown, J. D.
Harris, A. J.
Kalambaheti, Kitti
Lukasek, E. O.
Najafzadeh, Moktar
Williams, H. H., Jr.

Spooner:
Goetsch, F. H.
Matzke, R. W.
Olson, L. J.

Spring Green:
Kempthorne, G. C.

Spring Valley:
Avestruz, A. P.
Avestruz, N. L.

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.
Sallis, D. A.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Bickford, R. H.
Bosworth, W. C.
Dunn, A. G.
Eckberg, R. A.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Hacker, P. K.
Iber, F. C.
Kennedy, J. T.
Klasinski, C. A.
Kohn, A. M.
Milano, Angelo
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Rifleman, R. H.
Riordan, J. F.
Schierl, A. G.
Sciarrone, Francesco
Sevenich, J. R.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.

Stockbridge:
Knauf, J. A.

Stoddard:
Locher, R. A.

Stone Lake:
Marlewski, C. R.

Stoughton:
Nelson, D. L.
Nordholm, V. W.
Peterson, R. K.
Schammel, F. M.
Schoenbeck, P. J.
Schoenbeck, R. F.

Stratford:
Kroeplin, F. C.

Sturgeon Bay:
Beck, J. G.
Brook, J. J., Jr.
Evenson, R. G.
Grota, H. D.
Hobson, W. S.
Sheets, W. G.
Wagener, N. R.

Sun Prairie:
Behrend, J. F.
Green, R. E.
Hahn, M. F.
Nelson, E. J.
Russell, W T.
Syty, Joseph

Superior:
Anderson, R. T.
Doyle, T. J.
Ekblad, V. E.
Finn, Milton
Fruehauf, R. P.
Giesen, Conrad W.
Johnson, F. G., Jr.
Knights, J. A.
Krahl, Enzo
Lavine, I. H.
Lavine, M. M.
Mann, Robert
Mataczynski, R. R.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Riabov, S. N.
Rosin, L. R.
Scott, C. M.
Sellers, R. L.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.

Theresa:
Langenfeld, G. P.

Thiensville:
Elbe, T. D.
Herman, Murray
Kim, K. S.
Levy, E. S.

Thorp:
Connolly, James
Neis, F. P.

Tigerton:
Heise, L. F.

Tomah:
Kozarek, C. E.
Landmann, G. A., Jr.
Mubarak, J. S.
Ryan, C. J.

Tomahawk:
Bugarin, N. L.
Francisco, Orlando
Henderson, R. J.

Turtle Lake:
Halberg, A. C.

Twin Lakes:
Slocumb, C. O.

Two Rivers:
Kaner, S. L.
Kuljis, D. A.
Martin, R. E.
Mir, A. A.
Myers, R. E.
Weld, S. L.
Zlatnik, A. P.
Zlatnik, P. A.

Union Grove:
Esener, Ismail
Haedike, W. D.
Lawrence, P. J.
Schulz, G. J.
White, E. F.

Valders:
Thranow, J. A., Jr.

Verona:
Pellett, J. R.
Stuesser, G. J.

Viroqua:
Ender, C. A.
Gulbrandsen, L. F.
Kuehn, A. E.
Oppert, H. E.
Starr, R. A.
Vig, D. E.
Vig, De Verne W.
Vig, E. N.

Wabeno:
Tenley, O S.

Walworth:
Bruhn, I. J.
Coon, W. W.
Hansen, D. R.
Kroyer, T. J.

Washburn:
Telford, J. G.

Washington Island:
Rutledge, P. E.

Waterford:
Bardenwerper, H. W.
Dietz, R. J.

Waterloo:
Gagan, R. J.
Garman, J. S.

Watertown:
Baldwin, R. C.
Becker, J. H.
Burzynski, E. E.
Miller, E. A.
Nowack, L. W.
Reed, W. H.
Schuh, E. P.
Von Gradulewski, M. A.

Waukesha:
Alston, J. A.
Barber, J. L.
Bartos, J. A.
Bartos, R. E.
Bemman, K. C.
Bischel, J. R.
Bolger, James V., Jr.
Brown, W. E.
Buerger, E. J.
Buhl, J. L.
Burch, R. N.
Campbell, P. E.
Carroll, P. E.
Church, Ruth E.
Clothier, W. J. K., Jr.
Conklin, J. W.
Davies, E. B.
Davies, Gwilym
Desch, C. A.
Dugan, T. E.
Feulner, R. C.
Frantz, R. G.
Freeman, L. M.
Froeschle, R. P.
Fruchtman, M. Z.
Gallo, G. L.
Gantz, H. A.
Glazier, E. H.
Guy, J. R.
Harris, J. A.
Herman, L. H.
Hillan, D. D.
Just, J. R.
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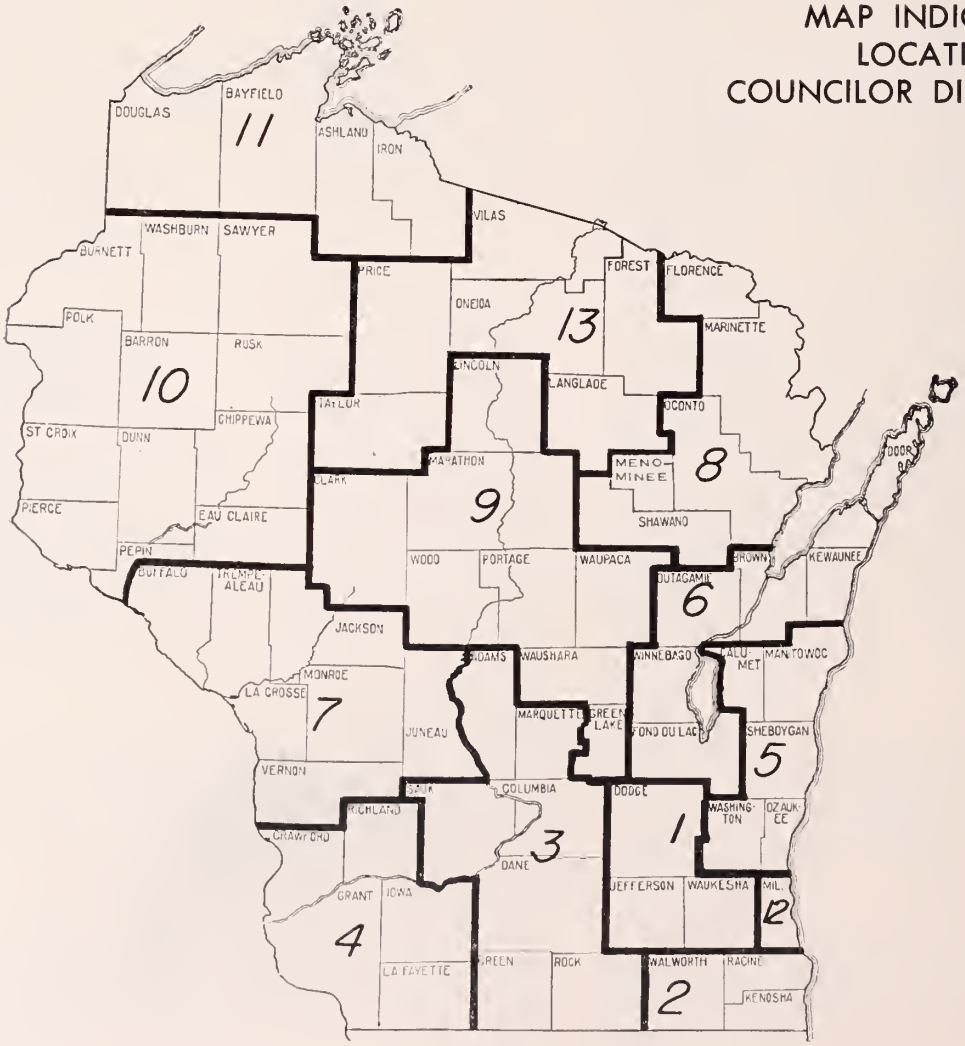

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Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk, and Rusk County Societies. **W. R. Manz, MD** (1968–1971), 204 East Grand Ave., Eau Claire 54701.

Eleventh: Ashland–Bayfield–Iron, and Douglas County Societies. **C. A. Grand, MD** (1966–1969), Masonic Temple Bldg., Ashland 54806.

Twelfth: The Medical Society of Milwaukee County. **L. J. Van Hecke, MD** (1966–1969), 6001 West Center St., Milwaukee 53203; **W. J. Houghton, MD** (1966–1969), 2943 North Oakland Ave., Milwaukee 53211; **W. J. Egan, MD** (1967–1970), 525 East Wells St., Milwaukee 53202; **S. L. Chojnacki, MD** (1968–1971), 3122 South Thirteenth St., Milwaukee 53215; **S. W. Hollenbeck, MD** (1968–1971), 2650 West Fond du Lac Ave., Milwaukee 53206; **J. M. Sullivan, MD** (1967–1970), 161 West Wisconsin Ave., Milwaukee 53203.

Thirteenth: Forest, Langlade, Oneida–Vilas, and Price–Taylor County Societies. **Marvin Wright, MD** (1968–1971), 1020 Kabel Ave., Rhinelander 54501.

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W. B. Hildebrand, MD (1967–1969), 59 Racine St., Menasha 54952.

R. E. Galasinski, MD (1967–1969), 3333 South 27th St., Milwaukee 53215.

J. M. Bell, MD (1968–1970), 516 Houston St., Marinette 54143.

E. L. Bernhart, MD (1968–1970), 2714 West Burleigh St., Milwaukee 53210.

Alternates

N. A. Hill, MD (1967–1969), 304 West Washington Ave., Madison 53703.

G. E. Collentine, Jr., MD (1967–1969), 2266 North Prospect Ave., Milwaukee 53202.

J. C. Fox, MD (1968–1970), 212 South Eleventh St., La Crosse 54601.

C. J. Picard, MD (1968–1970), 425 Twenty-first Ave., East, Superior 54880.

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* Map indicating location of councilor districts, page 78.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May. Dates in parentheses indicate beginning and expiration of term of office.

Standing Committees—1968-1969

State Medical Society of Wisconsin

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10425 West North Ave.

J. F. Brown, MD (1968–1971) ..... Rhinelander 54501
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1011 North 8th St.

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37880 Forrest Dr.

F. L. Schaefer, MD (1966–1969) ..... Menasha 54952
59 Racine St.

Enzo Krahl, MD (1966–1969) ..... Superior 54880
3600 Tower Ave.

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104 South Wisconsin St.

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650 South Central Ave.

D. R. Griffith (1966–1969) ..... Eau Claire 54701
314 Grand Ave. East

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203 Fourth St.

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422 Broad St.

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123 North Military Ave.

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650 South Central Ave.

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5001 Monona Dr.

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2108—63rd St.

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1950 Alverno Dr.

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Neurology & Psychiatry 1300 University Ave.

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Lyle Edelblute, MD (1966–1969) ..... Green Bay 54301
Radiology Bellin Memorial Hospital

Donald S. Schuster, MD (1966–1969) .... Madison 53705
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General Practice 3102 North 78th St.

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Immediate Past President

President—President-elect—Secretary

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Economic Medicine—Executive—Finances

Planning—Scientific Medicine

Council Committees:

Ad Hoc: The Medical Practice Act

Disaster Medical Care—Editorial Board

Commission on Medical Care Plans

Commission on Safe Transportation

Commission on State Departments

Commission on Health and Natural Resources

Committee on Medicine and Religion

Military Medical Service—Past Presidents

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Vice-chairman of the Council 161 W. Wisconsin Ave.

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Chairman, Economic Medicine ..... 722—15th Ave.

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Ex officio 505 East Division St.

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110 East Main St.

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2943 North Oakland Ave.

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161 West Wisconsin Ave.

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525 E. Wells St.

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257 Madison St.

E. J. Nordby, MD ..... Madison 53705
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PLANNING

W. R. Manz, MD ..... Eau Claire 54701
Chairman 204 E. Grand Ave.

M. F. Huth, MD ..... Baraboo 53913
203 Fourth St.

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PLANNING *continued*

C. A. Grand, MD ..... Ashland 54806
Masonic Temple Building

J. A. Sisk, MD ..... Fond du Lac 54935
566 Fifth St.

E. P. Ludwig MD ..... Wausau 54401
400 Strollers Lane

E. J. Nordby, MD ..... Madison 53705
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Ex officio 2715 Marshall Ct.

FINANCES

H. G. Bayley, MD (1967–1970) ..... Beaver Dam 53916
Chairman 138 Front St.

Marvin Wright, MD (1967–1970) .... Rhinelander 54501
1020 Kabel Ave.

J. W. Boren, Jr. MD (1968–1971) ..... Marinette 54143
1510 Main St.

S. L. Chojnacki, MD (1968–1971) .... Milwaukee 53215
3122 South 13th St.

J. E. Dettmann, MD (1966–1969) .... Green Bay 54301
519 South Monroe Ave.

W. J. Egan, MD (pro tem) ..... Milwaukee 53202
525 E. Wells St.

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E. J. Nordby, MD ..... Madison 53705
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SMS COUNCIL COMMITTEES 1968–1969

(Appointed by the Chairman of the Council and composed of members of the State Medical Society)

DISASTER MEDICAL CARE

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8700 West Wisconsin Ave.

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155 North Sawyer

D. L. Williams, MD ..... Madison 53703
30 South Henry St.

Harold Cook, MD ..... Wind Lake 53185
12325 Fries Lane

E. P. Rohde, MD ..... Galesville 54630

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1770 13th St.

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6745 West Wells St.

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400 Ceape Ave.

O. G. Moland, MD ..... Augusta 54722

D. S. Arvold, MD ..... Shawano 54166
117 East Green Bay St.

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133 Roosevelt Ave. East

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Box 908

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D. A. Jeffries, MD (1966–1969) ..... Shawano 54166
117 East Green Bay St.

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408 St. Francis Drive

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925 Mound St.

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COMMISSION ON MEDICAL CARE PLANS *continued*

W. E. Wright, MD (1966–1969) ..... Mondovi 54755
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Ear, Nose & Throat 2040 West Wisconsin Ave.

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Rehabilitation 12535 Stephen Place

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212 South 11th St.

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235 North Madison St.

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Secretary 505 E. Division St.

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Box 325

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1024 East State St.

Gunnar Gundersen, MD ..... La Crosse 54601
1836 South Ave.

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Two Thorstrand Rd.

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J. C. Griffith, MD ..... Milwaukee 53202
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1155 Farwell Dr.

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104 South Wisconsin St.

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723—58th St.

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304 West Washington Ave.

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* *Died during term of office as president-elect.*

† *Resigned, because of health, prior to taking office.*

‡ *Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.*

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Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

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* Centennial Award. † Deceased.
** 125th Anniversary Award.

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Since the establishment of this citation in 1959, the following persons have been so recognized:

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The Rev. Edward J. O'Donnell, S. J. (Chancellor of Marquette University) 1963
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. . . a career guide

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The publication is unique in its presentation. It is intended to supplement existing careers materials, and gives factual and statistical information on personal qualifications, educational requirements and opportunities, and employment possibilities in each of the fields. It places emphasis on Wisconsin.

Copies are distributed to guidance counselors in every Wisconsin school, and individual copies are available from the Wisconsin Health Council to youngsters interested in health careers.

Supplies are also available to physicians who participate in career days in their local schools; they may be obtained by writing the State Medical Society, Box 1109, Madison 53701.

The Wisconsin Health Council, which published the brochure, was formed in 1948 to stimulate citizen interest in public health in Wisconsin.

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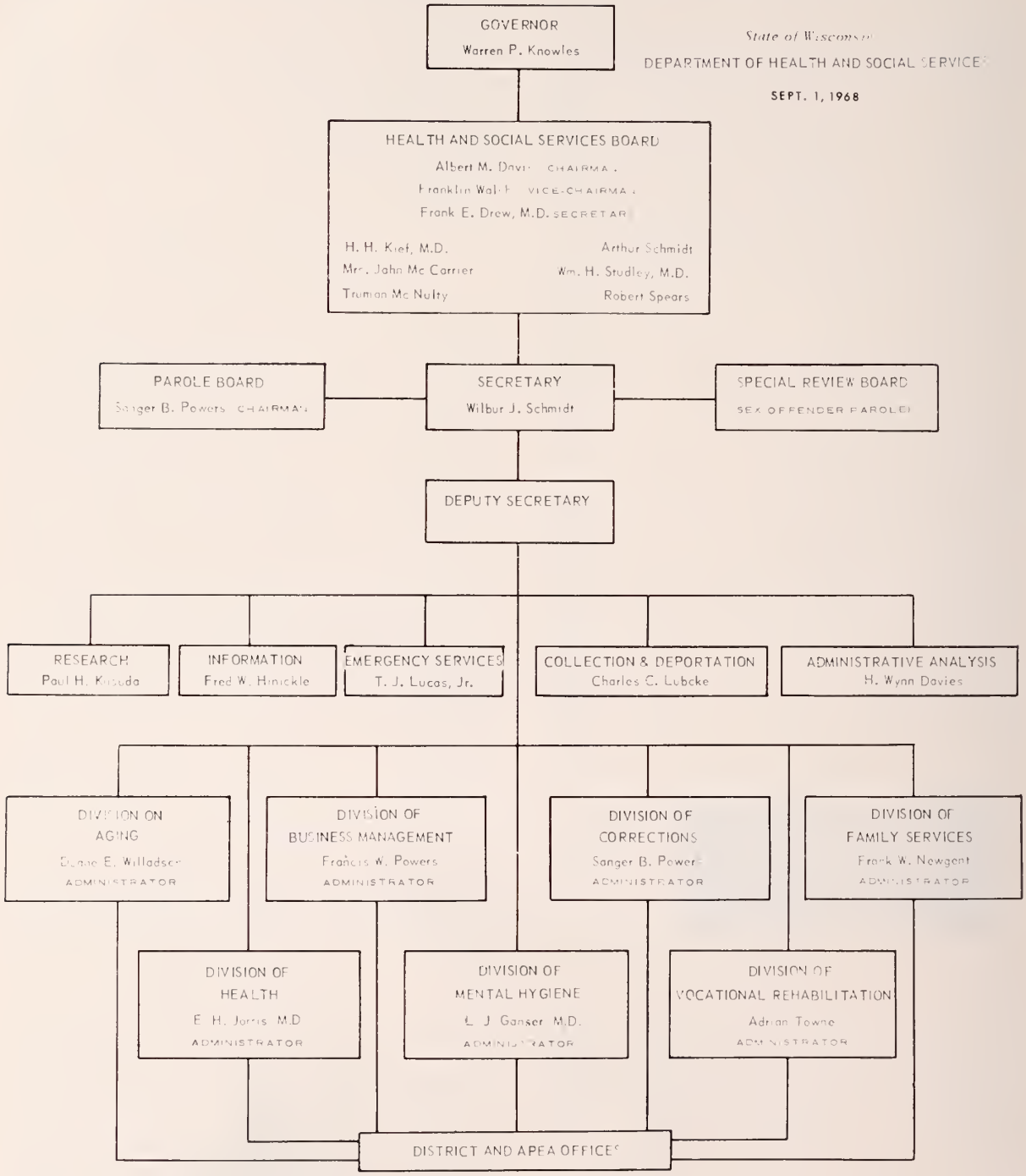

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Copies of this booklet are available upon request from the Wisconsin Nurses Association, Inc., 161 West Wisconsin Avenue, Milwaukee, Wis. 53203; or tel. (area code 414) 272–3670.

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Evaluation of Carbamazepine in the Management of Tic Douloureux and Other Painful Disorders

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■ TIC DOULOUREUX (trigeminal neuralgia) is one of the most excruciating pains that can afflict a patient. In the past, customary treatment has been alcohol injection or surgery involving one or another part of the trigeminal nerve. Of these methods, retrogasserian rhizotomy gives the most consistent and longest relief, but has the disadvantage of causing permanent anesthesia, and occasionally, disagreeable paresthesia. In elderly or debilitated patients rhizotomy may carry a definite risk.

Many drugs including analgesics, vasodilators, vitamins (B_1 and B_{12}), arsenicals, phenothiazines, anticholinergics, antispasmodics, and anticonvulsants, have also been used with varying success. As a rule, opiates have been avoided because of the danger of addiction in prolonged therapy.

In 1942, Bergouignan[1] first used the anticonvulsant, diphenylhydantoin (Dilantin) for trigeminal neuralgia. His trials were based on the theory advanced by Trousseau[2] (who had coined the term "tic douloureux") that the attacks of intense pain are caused by paroxysmal discharges in the trigeminal nucleus. At first, Bergouignan found the drug sufficiently effective so that surgery could be postponed in 50 percent of his patients, but after two years of therapy it remained effective in only 30 percent.[3] In addition, long-term doses of 400 to 600 mg daily required for adequate relief often produced severe signs of intoxication.

Almost 10 years later, other investigators[4] showed that the antispasmodic, mephenesin carbamate (Tolseram), also depresses trigeminal evoked potentials. This drug has been used with some success either alone[5] or combined with Dilantin.[6]

When a new anticonvulsant, carbamazepine (Tegretol*), became available in Europe about six years ago, it was used originally for the treatment of epilepsy. Chemically, carbamazepine is unrelated to the hydantoins, but is a tricyclic iminostilbine, closely resembling imipramine (Tofranil). However, because its pharmacological activity is similar to that of diphenylhydantoin, Blom[7] in 1962 tried the new compound in a small group of patients with trigeminal neuralgia. He found it more effective with fewer undesirable reactions than Dilantin. Recent animal studies[8] show that it depresses synaptic transmission in the trigeminal nucleus to a greater extent than does Dilantin. Since Blom's early trials,[7,9] other clinical reports[10–13] have described similar favorable results in trigeminal neuralgia in about 75 percent of cases. In most patients, the pain returns when the drug is withdrawn. In some, complete remission occurs, but of course, it is impossible to say whether this is due to the treatment or to the tendency to spontaneous remission. A double-blind

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* Tegretol, 5H-dibenz [b,f] azepine-5-carboxamide, brand of carbamazepine, supplied by Geigy Pharmaceuticals, Ardsley, New York.

TABLE 1—*Age and Sex of 61 Patients*

Age	Trigeminal Neuralgia			Other Painful Disorders			Complete Total
	Male	Female	Total	Male	Female	Total	
41-50	1	0	1	3	3	6	7
51-60	8	8	16	2	3	5	21
61-70	7	7	14	0	2	2	16
71-80	2	5	7	0	3	3	10
81-90	2	4	6	1	0	1	7
Total	20	24	44	6	11	17	61

study has shown that the effect of carbamazepine is definitely superior to the effect of placebo in true trigeminal neuralgia.[14]

Aside from true trigeminal neuralgia, the only other painful condition in which carbamazepine seems comparably effective is glossopharyngeal neuralgia.[15] Some good results also have been reported in cases of tabetic lightning pain[16] and thalamic pain.[17] The drug is usually ineffective in atypical facial neuralgia, postherpetic neuralgia, and paresthesia secondary to retrogasserian rhizotomy.

As with most effective drugs, adverse reactions do occur. Those most frequently observed are headache, nausea, drowsiness, dizziness, ataxia, confusion, and skin reactions particularly during the early weeks of therapy. Some sustained side effects were reported which subsided after discontinuation of the drug including a reversible illness closely resembling lupus erythematosus or dermatomyositis,[18] Stevens–Johnson syndrome,[19] and various skin rashes.[20] Two cases of fatal aplastic anemia have been reported.[21] Usually, most reactions may be reduced or avoided by starting with low doses and performing periodic blood tests, as well as liver and kidney function tests before and throughout treatment.

In patients with a known sensitivity to any of the tricyclic compounds, such as amitriptyline, desipramine, and imipramine, carbamazepine therapy is contraindicated.

The many favorable reports prompted our trial of the new drug in a group of 61 patients referred to the neurosurgical service at University Hospitals. All had severely painful disorders, in most cases, trigeminal neuralgia.

Materials and Methods

Patients. The 61 patients treated, 26 men and 35 women, ranged in age from 44 to 85 years. All but 7 were over 50 years old and the majority were 60 or older (Table 1). Diagnoses were: trigeminal neuralgia in 44 (1 also had glossopharyngeal neuralgia, and another had multiple sclerosis); glossopharyngeal neuralgia in 1; atypical facial neuralgia in 9; other facial pains in 5; occipital neuralgia in 1; and sciatic pain in 1.

Trigeminal neuralgia was more frequent in women and most often involved the second and third branches of the trigeminal nerve on the right side of the face (28 right and 16 left). This pattern of incidence concurs with the documented literature. The 44 patients had been suffering from 1 to 20 daily attacks of pain for periods up to 20 years. All but 4 (with a primary disorder) had had previous treatment: with Dilantin or other drugs (12), alcohol blocks (17), or surgical procedures (11).

General procedure. After complete histories were taken, all patients received a thorough physical and neurological examination with x-ray studies as indicated. Laboratory studies were done before therapy and at monthly intervals during drug dosage. These usually included urinalysis, blood tests (RBC, hemoglobin and/or hematocrit, WBC and differential, and platelet count); also, serum enzyme activity (SGOT, SGPT, LDH, aldolase and alkaline phosphatase), serum protein lability and electrophoresis, prothrombin time, BUN, glucose, uric acid and electrolyte determinations.

Dosage. All patients received an initial oral dose of 100 mg carbamazepine twice a day for 2 days, followed by 200 mg twice a day for 2 or 3 days. If the pain continued, the dose was increased to 200 mg three or four times daily as required. In the group, dosage ranged from 200 to 800 mg daily. When pain was under control, dosage was decreased or discontinued. Patients were observed on intermittent therapy for periods of 4 months to 2½ years.

Criteria of response. The effect of carbamazepine on the initial response of pain was listed under five categories.

1. *Complete relief.*
2. *Excellent to good relief:* occasional pain, but not severe enough to interfere with normal activities or to require any other therapy.
3. *Fair to poor relief:* decrease in pain, but inadequate control.
4. *No relief.*
5. *Worse.*

TABLE 2—*Initial Response in Trigeminal Neuralgia*

Previous Treatment	Degree of Relief					Total No. Patients
	Complete	Excellent–Good	Fair–Poor	None	Worse	
None	4*					4
Dilantin (alone or with other drugs)	8	3			1†	12
Alcohol block	7	8	2			17
Avulsion	4	1*	1	1		7
Decompression or rhizotomy	1‡		1			2
Surgery (followed by paresthesia)				2		2
Total	24 (54.5%)	12 (27.3%)	4	3	1	44
Satisfactory Response	36 (81.8%)					

*One patient had previous rhizotomy of other divisions; †had multiple sclerosis; ‡also had glossopharyngeal neuralgia.

TABLE 3—*Initial Response in Trigeminal Neuralgia According to Location of Pain*

Trigeminal Nerve Branch	Degree of Relief					Total No. Patients
	Complete	Excellent–Good	Fair–Poor	None	Worse	
Single Branch						
V^1	4	1				5
V^2	5	6		1		12
V^3	7	1	2			10
Subtotal	16 (59.3%)	8 (29.6%)	2	1		27
Satisfactory Response	24 (88.9%)					
Multiple Branches						
$V^1 + V^2$	3	1	1	1		6
$V^2 + V^3$	5	2	1	1	1	10
$V^1 + V^2 + V^3$		1				1
Subtotal	8 (47.1%)	4 (23.5%)	2	2	1	17
Satisfactory Response	12 (70.6%)					
Complete Total	24 (54.5%)	12 (29.3%)	4	3	1	44
Satisfactory Response	36 (81.8%)					

Initial Results in Trigeminal Neuralgia

Among the 44 patients with trigeminal neuralgia, 36 (82%) responded satisfactorily to initial treatment, in many instances on 200 to 300 mg of carbamazepine daily; of these 36, 24 (55%) had complete remission of pain and 12 (27%) had an excellent to good response. Four others had only fair to poor relief, 3 had no relief and 1 patient suffering from multiple sclerosis reported feeling worse (Table 2).

The majority of patients responded in less than 24 hours. Onset of response was 12 hours in 10 patients; 24 hours in 16; 1 week in 14; and failure in 4.

Further evaluation showed that age, sex, duration of symptoms, and number of daily attacks did not appreciably affect the response to carbamazepine. However, *location of pain* did appear to influence the response in some degree. When pain was limited to one division of the trigeminal nerve, the drug seemed slightly more effective than when two or three divisions were involved (Table 3).

Follow-Up in Trigeminal Neuralgia

The 44 patients with trigeminal neuralgia were followed for periods of 4 months up to 2½ years. Initially, 40 (91%) responded in some degree to carbamazepine: complete or excellent/good relief in 36 (82%) and fair/poor in 4 (9%). Of these 40 patients, 13 with complete remission have so far continued in remission for periods varying from 3 weeks to over 2 years after the drug was discontinued; 12 others are still taking the drug with satisfactory control of pain; and the remaining 15 have experienced a recurrence of pain after 1 week to 2 years, either while on the drug or after remission.

TABLE 4—*Response to Second Course of Therapy in 21 Patients*

Treatment	Degree of Relief			Total
	Complete	Partial	None	
2nd Drug Course	5	1*	4*	10
Alcohol Block	1	1		2
Avulsion	2			2
Alcohol Block + Avulsion		1		1
Rhizotomy	11			11

*These 5 patients subsequently had surgery and are included in other procedures, making actual total of 21 patients.

Relapse. Examination of the data in relation to factors tending towards relapse, showed that recurrence of pain was:

1. More frequent after previous avulsion.
2. About half as frequent in older patients (over 60).
3. Absent in first division involvement; and most frequent in second division or second plus first division involvement.
4. Experienced by all 4 patients with initial fair/poor response, compared to about one-third of those with initial complete or excellent/good response.
5. Apparently not influenced by duration of the disorder, frequency of daily attacks, nor daily dosage.

Treatment after relapse. The 15 patients suffering recurrence of pain received further treatment with carbamazepine, alcohol block or surgery (Table 4). Of 10 patients given a second course of the drug at increased doses up to 800 mg daily 5 had complete relief. The 5 who derived little or no benefit from the second drug course, as well as the 5 others with recurrent pain, elected alcohol block or surgery.

Surgery in others. Six additional patients who underwent surgery included 2 who had discontinued carbamazepine because of rash and 4 who were doing well on the drug, but later found the laboratory tests inconvenient and expensive. Table 4 shows the response of the 21 patients on the second course of therapy.

Initial Results in Other Painful Conditions

Among the 17 patients with other painful disorders, only 4 (24%) responded well with 2 *complete* remissions and 2 *excellent/good* results (Table 5). One of the complete remissions was in a patient with glossopharyngeal neuralgia. It is interesting that in another patient (Table 2) with this disorder in addition to trigeminal neuralgia, carbamazepine also produced complete relief of pain.

Complete relief also occurred in 1 patient (recent mastectomy) with atypical facial neuralgia, and adequate relief occurred in 1 with "tic-like" pain in maxillary cylindroma. However, the drug was ineffective in the great majority (76.5%) with other painful states (Table 5).

Adverse Reactions

Among the 61 patients treated with carbamazepine, 19 (31.1%) reported 26 reactions, in most cases mild and transient (Table 6). One patient (treated for trigeminal neuralgia) with a long history of thrombophlebitis, had an acute episode after 14 days on the drug, but the condition cleared up completely within a few days without interfering with therapy. Two patients (3.3%), 1 of whom had multiple sclerosis, discontinued the drug because of rash.

Periodic laboratory tests in 57 patients (4 were lost to follow-up) did not differ appreciably from the pretreatment recordings. The few exceptions included 1 patient whose platelet count decreased from 480,000 to 116,000 in 5 days, but this returned to normal within a few days without discontinuing the drug. In another patient with an elevated platelet count of 766,000, the drug was discontinued because the patient was already in complete remission; repeat platelet count was normal. One instance of increased alkaline phosphatase of 66.5 occurred in a woman who had undergone a recent mastectomy. Interestingly, she was 1 of 2 patients with atypical facial neuralgia who responded favorably to the drug; after complete remission and withdrawal of medication, alkaline phosphatase became normal.

Discussion

Before the introduction of carbamazepine, neurosurgical management was the only satisfactory method for obtaining relief of the severe pain of trigeminal neuralgia. Our experience and that of others have confirmed that the new drug has substantially reduced the need for alcohol block or surgery and in most cases is superior to other medications used formerly.

Some of our patients at first required doses of carbamazepine up to 800 mg daily, but later many did well on doses of 200 to

TABLE 5—*Initial Response in Other Painful Conditions*

Diagnosis	Degree of Relief					Total No. Patients
	Complete	Excellent–Good	Fair–Poor	None	Worse	
Glossopharyngeal neuralgia	1					1
Atypical facial neuralgia	1*	1	2	3	2	9
Other facial pains		1†		4		5
Occipital neuralgia				1		1
Sciatic pain				1		1
Total	2	2	2	9	2	17
Satisfactory response	4 (23.5%)					

*Patient had recent mastectomy.
†Pain due to cylindroma involving the trigeminal nerve.

300 mg and could subsequently discontinue medication while they enjoyed complete remission. Although 82 percent responded favorably, it must be remembered that about 33 percent may relapse, either during remission or while on the drug. This was observed in our group of trigeminal neuralgia patients followed for periods up to 2½ years.

However, in many cases, therapy resumed at increased doses restored complete relief without resorting to more radical measures. Twelve (27%) of the 44 patients later required alcohol block or surgical procedures because of poor response or recurrent pain. It appears that although the drug is effective initially in controlling attacks of pain in the majority of patients, its effectiveness is limited in time.

When surgery is contraindicated and recurring pain does not respond to the drug, there is fortunately an alternative. Dilantin combined with carbamazepine[9, 12] has proved successful in some patients. Tolseram given alone, or a combination of all three drugs can also be tried. It was noteworthy that in our series, carbamazepine was effective in 4 patients previously unresponsive to combined Tolseram and Dilantin.

In the majority of patients who improved on the new drug, pain disappeared within 24 hours. We found that if patients did not respond well after one week, further therapy was of little value and recurrence of initial severe pain was almost certain. Although age, sex, duration of the disorder, and incidence of daily attacks apparently did not influence the response, location of the pain seemed to do so. Patients with pain in only one division of the trigeminal nerve tended to get better relief with less likelihood of relapse. Five of our patients, with first division pain only, had satisfactory relief (4 complete and 1 excellent/good) with no recurrence of pain to date. Further experience duplicating this result would be of practical importance, since medical therapy is certainly preferable to surgery in view of the risk of corneal anesthesia.

Among the patients with other painful disorders, carbamazepine produced complete relief in the 2 with glossopharyngeal neuralgia, excellent/good relief in 2 with other facial pain, and little or no relief in 76 percent of the group.

In general, our results correspond with those compiled in a recent review[22] including almost 700 patients. In trigeminal pain secondary to multiple sclerosis, Paget's disease, or tumors of the surrounding tissues, the response to carbamazepine cannot be predicted but in some cases the drug may prove valuable. They found it rarely helpful in atypical facial neuralgia and ineffective in facial paresthesia secondary to retrogasserian rhizotomy and herpetic neuralgia, and in other types of neuralgia. Another report[23]

TABLE 6—*Adverse Reactions Among 61 Patients**

Reaction	Trigeminal Neuralgia†	Other Painful Disorders‡	Total Incidence
	Incidence	Incidence	
Dizziness	6	1	7
Light-headedness	1	1	2
Ataxia	2	1	3
Disorientation	1		1
Drowsiness	1	1	2
Eye Disturbance			
Diplopia	1		1
Accommodation	1		1
GI Upset	4		4
Rash and Itching	2		2
Facial Burning Sensation (on side of pain)	2		2
Thrombophlebitis (increase of)	1		1

*Among all 61 patients, 19 (31.1%) had 26 reactions; 2 (3.3%) discontinued the drug because of rash and itching.
†Among 44 patients, 15 (34.1%) had 22 reactions.
‡Among 17 patients, 4 (23.5%) had 4 reactions.

notes that in some chronic conditions, particularly daily headache and diabetic neuritis, the tricyclic antidepressants (imipramine and amitriptyline) have been tried with good results, but we have not used these compounds in this study.

Carbamazepine has afforded prompt and prolonged control of severe pain in many patients. However, the possibility of serious reactions must still be kept in mind. In our series, with careful supervision of dosage and periodic laboratory tests, adverse effects were mainly mild and transient and presented no problem. Only 2 patients (3.3%) discontinued medication because of sustained rash and itching which subsided soon after drug withdrawal.

Four patients requested surgery in spite of good results from carbamazepine therapy for the sake of convenience. Twelve additional patients required other types of procedures (alcohol block, avulsion and/or gasserian ganglion surgery). This indicates that although carbamazepine is usually very effective initially, the duration of its effect is variable. On the other hand, despite the recurrence of pain in some of our patients, the overall results in trigeminal and glossopharyngeal neuralgia were most gratifying, especially considering that previous treatment with other drugs, alcohol block and/or avulsion had given inadequate or short-term relief. Undoubtedly, the introduction of carbamazepine is a significant contribution to the management of these painful disorders.

Summary

A group of 61 patients with trigeminal neuralgia (44) or other painful disorders (17) received oral doses of carbamazepine (Tegretol), a new anticonvulsant. The majority (60 years of age or older) had a long history of frequent, severe pain previously treated by alcohol block, nerve avulsion, or other drugs which gave inadequate or short-term relief.

Dosage of carbamazepine was started at 100 mg twice daily, gradually increased up to 800 mg daily if required, then decreased or discontinued when adequate control of pain was attained. Follow-up continued for periods up to 2½ years.

In the 44 patients with trigeminal neuralgia 36 (82%) initially responded well, usually within 24 hours with complete or almost complete remission. One of these patients also had glossopharyngeal neuralgia. Subsequently, about one-third of those who improved had recurrent pain which in some cases responded to further drug treatment, while others required alcohol block or surgical intervention. Eleven (25%) had complete relief of pain after gasserian ganglion surgery.

In the 17 patients with other painful conditions only 4 (24%) including 1 with a glossopharyngeal neuralgia had a satisfactory response.

Careful monitoring of dosage and laboratory tests is essential to reduce the possibility of serious reactions. Adverse effects in about one-third of the group were usually mild and transient, and only 2 patients (3.3%) discontinued therapy because of rash.

With proper precautions, the use of carbamazepine may eliminate or long defer the need for surgery in many patients suffering from trigeminal neuralgia.

Addendum

Since this paper was submitted for publication, 4 patients required other procedures for the relief of pain (alcohol injection 2 patients; retrogasserian rhizotomy 2 patients).

Subsequent to this study, during the past 12 months, an additional 19 patients, 12 of whom had trigeminal neuralgia, have received carbamazepine. Results obtained in these patients were similar to those described in this paper. □

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Parenchymatous Cerebellar Degeneration Associated with Carcinoma of the Lung

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■ CARCINOMATOUS cerebellar degeneration associated with carcinoma of the lung and other neoplasms has been reported sporadically since the report of Brouwer and Biemond.[1] Despite the rising interest in carcinomatous neuromyopathy in recent years, relatively few pathologically verified cases of subacute cerebellar degeneration have been reported. It is generally accepted that there is no constant relationship between the clinical course of the cerebellar degeneration or that of other neuromyopathies and their associated neoplasms. However, the concept seems to linger and some reports[2] sustain it, that removal or other treatment of the primary neoplasms influence favorably the clinical course of the cerebellar deficit. Whereas, Turner[3] and Henson and associates[4] have reported spontaneous remission in other forms of carcinomatous neuromyopathies, such has not been considered characteristic of the cerebellar degenerations.[5]

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This article reports a case of parenchymatous cerebellar degeneration associated with an oat-cell carcinoma of the bronchus whose cerebellar signs of subacute onset later remitted in the face of the relentless progression of the untreated tumor. The patient was neurologically asymptomatic two months prior to his death from this neoplasm. Our case supports the view that improvement of the neurological syndrome coincidental with treatment of the primary neoplasms cannot be considered causally related.

Case Report

A 45-year-old, white, married, male veteran was admitted to a local hospital July 14, 1965, presenting with a history of vertigo, persistent projectile vomiting of four days' duration. He was a chronic smoker of two packs of cigarettes per day, had a chronic mild cough for many years, but denied any new symptomatology referable to the chest. The patient had lost 55 pounds in the past seven months for undetermined reasons. The patient denied excessive, or even significant drinking.

Chest x-ray film on admission revealed a left hilar mass with patchy nodular infiltration of the left upper lobe (Fig 1). Four days after admission, the patient developed diplopia and marked ataxia of gait. A lumbar puncture at that time revealed a clear spinal fluid under normal pressure containing 5 lymphocytes per high-power field and 66 mg/100 ml of protein. The colloidal gold curve was negative.

Fig. 1—Chest roentgenogram in August 1965, showing fullness of the left hilum and patchy nodular infiltration in the left lateral infraclavicular area.

The patient was transferred to our hospital a month later. Examination revealed a thin, white man looking older than his stated age. Significant findings were confined to the neurological and respiratory systems. He was alert and of normal mentality. His speech was slurred. An internuclear ophthalmoplegia was present. A coarse, irregular nystagmus with a rotary component was present in all directions of gaze, but was most marked on left lateral gaze. The pupillary reactions to light were prompt on the left, sluggish on the right. Bilateral pupillary hippus was noted in response to light. The visual fields were full and the funduscopic examination was normal.

Movements of the face, jaw, tongue, and palate were all normal. The patient was unable to stand because of marked trunkal ataxia. With support, his gait was wide-based and grossly ataxic (Fig 2). Heel to shin testing revealed moderate segmental ataxia of the right leg and mild ataxia of the left leg. By contrast, only minimal dysmetria of the upper limbs was present. No focal weakness was noted.

The right biceps tendon reflex was hyperactive as compared to the left, but the remainder of the reflexes were symmetrical and normal. No pathological reflexes were observed. The sensory examination revealed no abnormalities. The patient was not in respiratory distress; however, dullness to percussion was noted over the left infraclavicular area with impaired breath sounds in this region. No rales were present. The remainder of the physical examination was not remarkable.

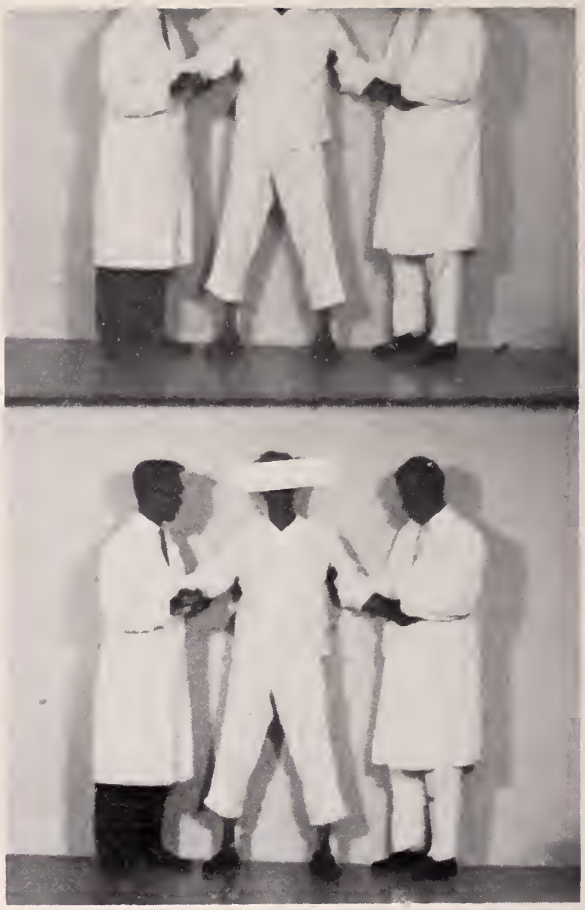

Fig. 2—Sequence from a gait movie showing the wide-based stance and severe ataxia of gait.

A chest roentgenogram on admission revealed that the left upper lobe infiltrate had increased in severity as compared to the previous month. An electroencephalogram (EEG) revealed a focal slow wave activity in the right frontotemporal region. However, skull films, brain scan, and pneumoencephalogram were normal. The spinal fluid at this time contained 24 mg/100 ml of protein and 92 mg/100 ml of glucose. No malignant cells were seen on smear of the spinal fluid. No fungi or bacteria were identified on smear or culture of the spinal fluid. Left axillary and scalene node biopsies were negative for tumor cells. Hemoglobin, white cell count and liver function tests were all normal. Serology of the spinal fluid and peripheral blood were negative.

Six weeks after admission a thoracotomy revealed an unresectable left upper lobe tumor with extensive hilar metastases. Only a biopsy specimen was obtained. This revealed an undifferentiated (oat-cell) carcinoma compatible with an origin from the lung (Fig 3). The patient refused palliative radiotherapy and was discharged home in October 1965.

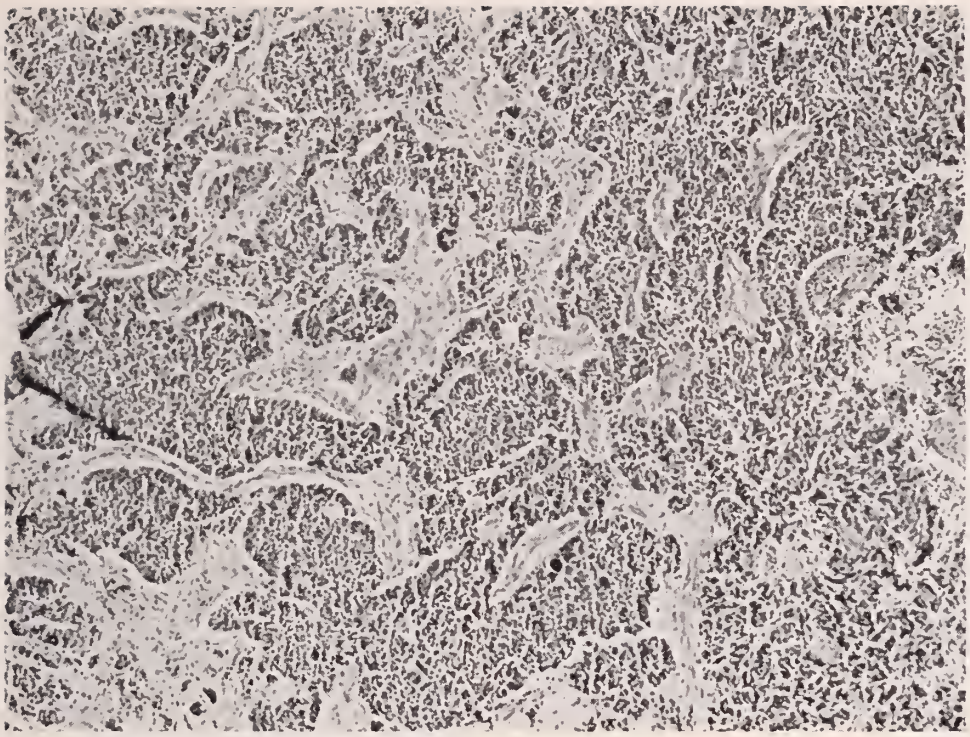

Fig. 3—Biopsy specimen of left hilar mass showing islands of medium and small size cells, with dark and irregular nuclei and scanty cytoplasm. Occasional palisading along the edges of the islands. Compatible with an oat-cell carcinoma of the lung.

Throughout this first admission to the Veterans hospital from August to October, the patient remained unable to walk because of severe ataxia and was confined to a wheel chair. However, the nystagmus had improved and was minimal. Vertigo and vomiting gradually improved over the course of his hospitalization.

He was readmitted in May 1966, complaining of tightness in his chest on the left side and progressive hoarseness. Physical examination revealed changes compatible with progression of the tumor in the left thorax. A chest x-ray film revealed an almost completely opaque left hemithorax (Fig 4). As no pleural fluid was obtained from repeated thoracenteses, it was felt that this opacity represented massive tumor growth since September 1965.

By contrast, neurological examination at this time revealed striking improvement in the patient's cerebellar brain-stem syndrome. The patient was now able to walk without assistance, showing no ataxia of gait. (Fig 5). Vertigo and diplopia had completely subsided. Vomiting had ceased, although occasional nausea persisted. On examination he was again found to be of normal mentality. His voice was hoarse, but not dysarthric. The extraocular movements were full. Movements of the face, jaw, tongue, and palate were normal. Hearing was normal. Only slight dysmetria was noted on segmental movement of the lower extremities. No focal muscular weakness or sensory deficit was noted. Tendon reflexes were as found previously. No pathological reflexes were elicited. The patient again refused palliative radiotherapy and was discharged without any specific treatment.

The patient was seen as an outpatient July 11, 1966. He was able to walk in a normal fashion. Extraocular movements were again normal and no nystagmus was present. Eleven days later the patient was admitted as an emergency in acute respiratory distress and died within 24 hours.

Autopsy examination revealed an undifferentiated oat-cell carcinoma of the left lung with extension to anterior and posterior mediastinum, right hilum, esophagus, and trachea. A metastatic lesion was found in a parathyroid gland. No metastases were present in the central nervous system on gross examination. Microscopic examination (Figs 6 and 7) showed a severe loss of Purkinje cells in the cerebellar cortex and degenerative changes present in those remaining, with absent nuclei and change in shape of the cells. Unfortunately, the brain sections were discarded before a complete neuropathological evaluation could be made.

Discussion

The characteristically acute or subacute onset of symptoms in carcinomatous cerebellar degeneration and some of the other carcinomatous neuromyopathies, their variable course in relationship to the associated tumor, and the frequent arrest or remission of signs, may suggest areas in which the

Fig. 4—Chest x-ray film in May 1966, showing elevation of the left diaphragm and almost complete opacity of the chest on the left side.

pathogenesis may be found. The following is a brief review of the theories which have been considered in the previous and current literature. Two of these hypotheses will be tentatively applied to the present case in an attempt to explain its curious evolution.

Casper in 1929,[6] and Brouwer and Biemond in 1938,[1] were among the first to recognize the relationship between cerebellar degeneration and malignant neoplastic disease. These authors postulated that a congenital predisposition to cerebellar disease was a requisite for the development of this form of carcinomatous neuromyopathy. Although this would help explain the rarity of cerebellar degeneration as opposed to the relative frequency of carcinomata, we are unaware of any case reports containing a family history of cerebellar disease.

These early authors also hypothesized that the cerebellar disorder was due, in most cases, to a toxin liberated by the tumor which destroyed the Purkinje cells. The precise nature of this toxin was never elaborated. Subsequently, however, several authors began to recognize how frequently the course of a neuromyopathy failed to parallel that of the malignancy.[4, 7] It was also seen that no correlation between tumor size and the incidence or severity of the neuromyopathies existed.[2, 7, 8] Such statements applied

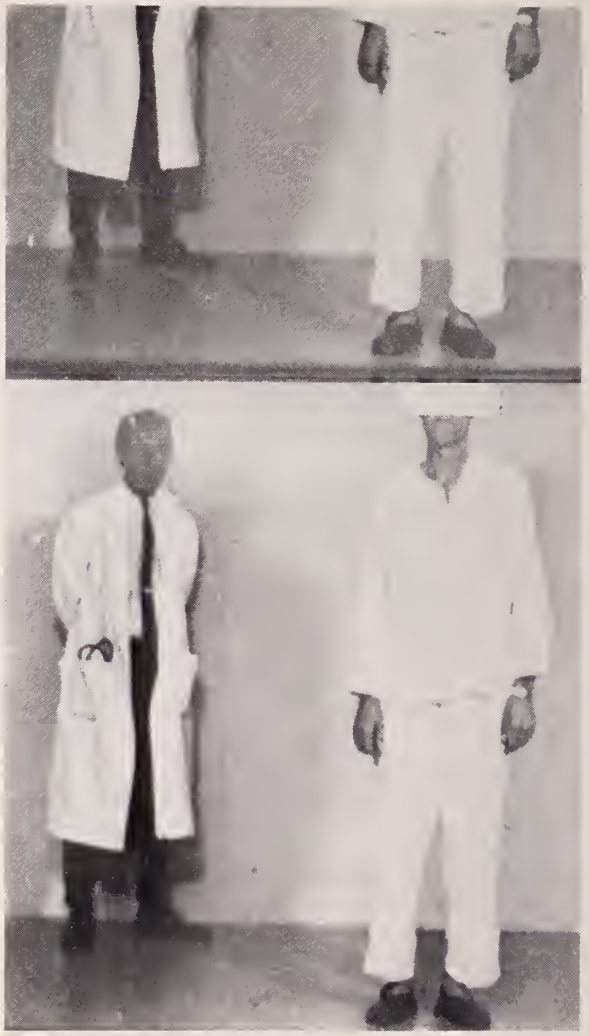

Fig. 5—Sequence from a gait movie in May 1966, showing normal posture, station, and gait.

to carcinomatous cerebellar degeneration as well as to the other forms of neuromyopathy. These observations, plus the low incidence of cerebellar degeneration among tumor patients, brought the toxic theory into disfavor.

Parker and Kernohan in 1933[9] considered that the gradual loss of Purkinje cells with advancing age, as demonstrated by Ellis[10] in normal subjects, indicated an increasing vulnerability of these structures to disease processes. Brain, Daniel and Greenfield[11] also felt that aging of Purkinje cells could play a role in carcinomatous cerebellar degeneration. Although this may be true, case reports of patients aged 19[12] and 32[13] years would appear to demonstrate that this factor is not requisite for the development of the disorder.

Parker and Kernohan[9] suggested that the subacute cerebellar degeneration in their

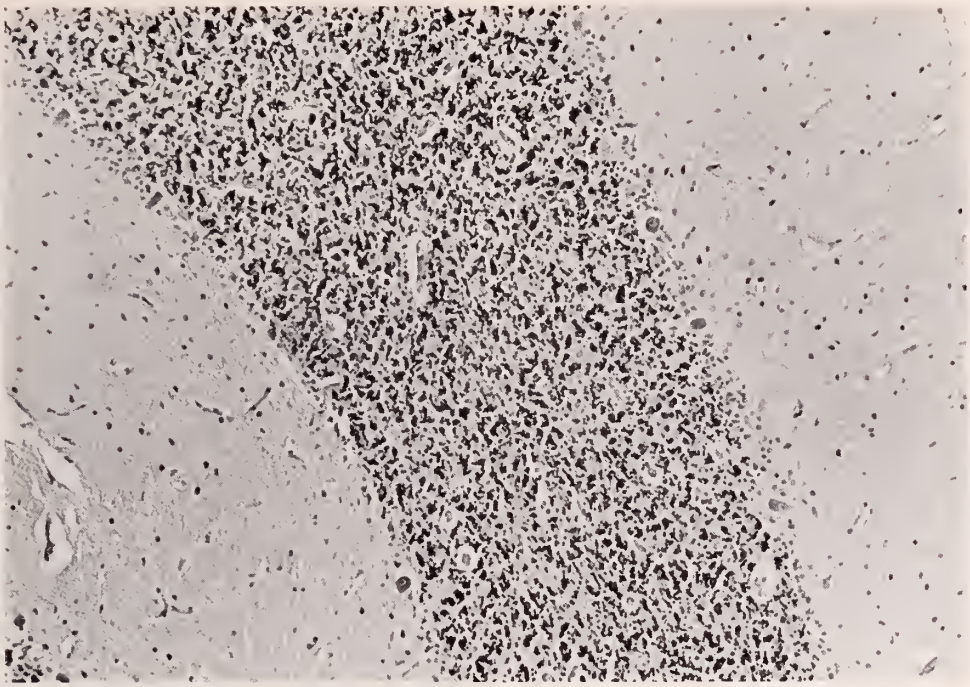

Fig. 6—Low-power view of a section of the cerebellar cortex showing considerably reduced number of Purkinje cells.

Fig. 7—High-power view of the cerebellar cortex showing the degenerative changes in the remaining Purkinje cells.

patient with carcinoma of the ovary was due to the flare-up of a chronically harbored viral infection at a time of impaired host resistance. Since then, the possible role of a viral infection in the production of carcinomatous cerebellar degeneration and other neuromyopathies has often been debated in the literature. Although no virus has ever been isolated from the cerebellum in this disorder, there are certain features of the disease

which suggest this theory. A study of reported cases appears to indicate that damage to the cerebellum occurs in many patients over a relatively short period of time as indicated by the subacute onset, fairly rapid development of the complete symptomatology, and the occasional arrest or remission of symptoms.[5] Such a course would be consistent with that of a viral cerebellitis. Moreover, the diffuse loss of Purkinje cells and the perivascular and meningeal round-cell infiltration, two characteristic pathological features of the disorder, have been described in known viral infections of the cerebellum.

Much discussion in the literature has centered around the significance of this round-cell infiltration seen in carcinomatous neuromyopathy. Brain, Daniel and Greenfield[11] considered it to be a reaction to degenerating tissue and that it did not represent a viral infection. Henson, Russell and Wilkinson,[4] however, found that round-cell infiltration in cases of carcinomatous neuromyopathy was not confined to areas of degenerating tissue, and therefore, suggested that the viral theory should be pursued. Similarly, Croft and associates,[14] noting the resemblance between the viral encephalitides and inflammatory lesions seen in carcinomatous sensory neuropathy, suggested that a neurotrophic virus, harbored by the tumor itself, is responsible for these lesions.

What means would allow a viral infection, regardless of its source, (harbored chronically by the host, a passenger of the tumor, or arriving de novo from the environment) to attain the cerebellum or other parts of the nervous system? Again, this is an unsettled question. However, a clue to one possible method may be found in the high incidence of oat-cell carcinomata of the bronchus among carcinomatous cerebellar and other neuromyopathies.[5, 15] O'Riordan and associates,[16] in a study of corticotropin-secreting tumors, found that 62 of their 118 cases were oat-cell carcinoma of the lung, an incidence five times that of thymoma, the next most common type. It has been suggested that the impaired, immune mechanisms in these cases, consequent to a high level of circulating steroids, may permit a viral infection to gain the cerebellum or other parts of the nervous system.[17] Despite these interesting associations, the viral theory remains unproven. Immunological, hormonal, and viral studies are required in order to affirm or deny it.

In assessing the relationship between the tumor process and its associated neuromyopathy, the profound nutritional and metabolic changes occurring with malignancy have not been ignored.[3, 4, 18] Such alterations would well apply to cases of cerebellar degeneration as this organ is well known to be vulnerable to this type of insult. The wasting of body tissues in patients with malignancy is often out of proportion to any concomitant impairment of intake and absorption of food. Changes in fat metabolism and the increased caloric expenditure during tumor growth undoubtedly contribute to this.[19]

Wiseman and Ghadially[20] discuss the superiority of the tumor cell over the host cell in competition for available amino acids. This is felt to be a major factor in the production of protein depletion of the patient's normal cells. Costa[19] feels that the severity of these metabolic effects are more a function of the stage of tumor growth than of its total mass.

Rat experiments have shown that the metabolic effects of certain tumors undergo more rapid changes early in the course of tumor growth than at other times.[21] If such proves to be the case among human patients, the development of a significant neurological deficit while the tumor is occult may be explained. Again, nutritional and metabolic balance studies in patients with carcinomatous neuromyopathy are necessary to test this hypothesis.

Would any of the hypotheses outlined above explain the clinical picture in the case herein described, especially the lack of correlation between the course of the cerebellar degeneration and that of the associated neoplasm? To summarize briefly the clinical course, this 45-year-old man lost 55 pounds over a seven-month period. He then subacutely developed signs of gross cerebellar and brain-stem dysfunction at which time an inoperable oat-cell carcinoma of the lung was found. Over the succeeding months, the neurological signs gradually regressed as the tumor grew. Shortly before his demise from the malignancy, the patient presented a normal neurological examination. In contrast to this, postmortem sections of the cerebellum demonstrated a severe loss of Purkinje cells.

The subacute development of the complete neurological picture followed by gradual recovery appears to indicate, as Brain and Wilkinson[5] have suggested, ". . . that the damage to the cerebellum occurs rapidly, once and for all." It is well possible that, in the wake of impaired resistance, the patient developed an acute, viral cerebellitis from which he gradually recovered. The course much resembles that of the viral cerebellitides as described by Dow and Moruzzi[22] and by Bennett and Peters.[23] The absence of inflammatory cells in the cerebellum 12 months after the initial episode would not be against this hypothesis. Unfortunately, we have no viral studies to prove such an etiology.

Alternatively, it can be postulated that the profound weight loss represented significant nutritional derangements wrought by the otherwise asymptomatic neoplasm and that these changes took their toll on the cerebellum. The acuteness of the nervous system manifestations is not against this hypothesis as Wernicke's encephalopathy and Korsakoff's psychosis, both of which have a nutritional-metabolic etiology, may present themselves abruptly. Moreover, it is noted that the patient subsequently maintained his weight over the succeeding months while the cerebellar signs were improving. This may have reflected a stabilization of his metabolism, allowing for some recovery of cerebellar function.

Lastly, we turn to the disparity between this man's ultimately mild ataxia and the severe loss of Purkinje cells found at autopsy. This raises the question of the role of extracerebellar compensation for cerebellar dysfunction. In reporting three cases of cerebellar atrophy without ataxia, Lichtenstein and Levinson[24] state that compensation for a cerebellar deficit can be observed in an adult when the degeneration occurs as a single episode. Extracerebellar compensation may well have occurred in our case. This would further account for the discrepancy between the course of the neoplasm and that of its associated cerebellar-type deficit.

Summary

We have presented a case of subacute cortical cerebellar degeneration in association with an oat-cell carcinoma of the lung. This case possesses the unique feature of remission of cerebellar symptoms while the tumor was actively progressing. In an attempt to explain the divergence in the course of the two diseases, it has been suggested that the Purkinje cells succumbed either to a viral cerebellitis or to carcinoma-induced nutritional and metabolic derangements. The role of extracerebellar compensation has also been considered. □

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Polyethylene Catheter Embolization to the Heart

REPORT OF TWO CASES

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■ THE USE OF INDWELLING polyethylene intravenous catheters has become very common and has contributed positively to improved patient care. These catheters make possible the long term infusion of vital fluids and medications and also provide a permanent portal for diagnostic measurements of vascular pressures and chemistries. However, the use of permanent polyethylene catheters is not without its hazards. Local as well as systemic complications are encountered frequently. The purpose of this paper is to point out the dangers in the use of permanent plastic catheters and how these dangers may be prevented before they occur and how they should be treated after they occur.

We have added an additional 2 cases of intracardiac catheters to the 15 cases previously reported in the American literature. Of a total of 17 cases, 12 patients had no treatment. Eight of these patients died of directly related cardiopulmonary complications. The 5 patients who underwent removal of the catheters are all alive and asymptomatic.

Case Reports

Case 1.—A 19-year-old white man was admitted to the hospital after ingestion of 2400 mg chlorprothixene (Taractan), 1200 mg diphenylhydantoin sodium (Dilantin), 4 gm chloral hydrate, and 300 mg ethchlorvynol (Placidyl) in a suicide attempt. The patient entered comatose with an intracatheter in the right antecubital vein which had been inserted at an emergency hospital. After admission to the medical ward, the patient gradually became more alert and agitated and started thrashing and flailing his arms. Eight hours after admission the right arm was swollen. Removal of the tape revealed only the metal intracatheter needle without its accompanying plastic tube. A tourniquet was immediately applied to the upper arm and a cutdown into the antecubital area failed to reveal the plastic catheter. X-ray film of the right arm similarly failed to show the plastic catheter, but a chest roentgenogram revealed the catheter present in the right heart (Fig 1). The patient was asymptomatic, and physical examination as well as laboratory studies were normal. Electrocardiographic studies showed only a sinus tachycardia. The Thoracic and Cardiovascular Service was consulted, and after review of the literature, it was recommended that the patient undergo immediate removal of the plastic catheter from the heart. Sixteen hours after admission the patient was taken to surgery, and through a median sternotomy incision the plastic catheter was removed from the right atrium. Postoperatively he did well and was discharged to a psychiatric hospital on the seventh postoperative day. Figures 2 and 3 illustrate the removed catheter specimen and its transposition on the chest x-ray film to prove its complete removal.

Case 2.—A 62-year-old white woman with polymyositis and pneumonia was admitted to the hospi-

Fig. 1—Demonstrates the plastic catheter in situ in the right ventricle as seen by standard P–A chest x-ray film.

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tal in critical condition. Eight days after admission the right subclavian catheter was missing and chest x-ray film revealed the catheter in the superior vena cava. During the next three days, serial films revealed that the catheter had migrated and lodged in the right atrium (Fig 4). The patient's primary critical condition precluded any attempt at surgical removal of the catheter. The patient's course was progressively downhill and she died on the twenty-seventh hospital day. Autopsy revealed the causes of death to be polymyositis, bronchopneumonia, and pulmonary edema. The plastic catheter was found in the superior vena cava extending through the right atrium into the right ventricle. There was no erosion, irritation, or damage to the valve or myocardium. Her death was not felt to be directly related to the "lost" subclavian catheter.

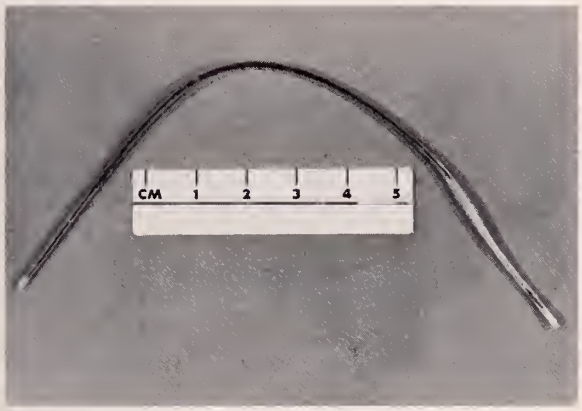

Fig. 2—Illustrates the plastic catheter specimen which was removed from the patient's heart.

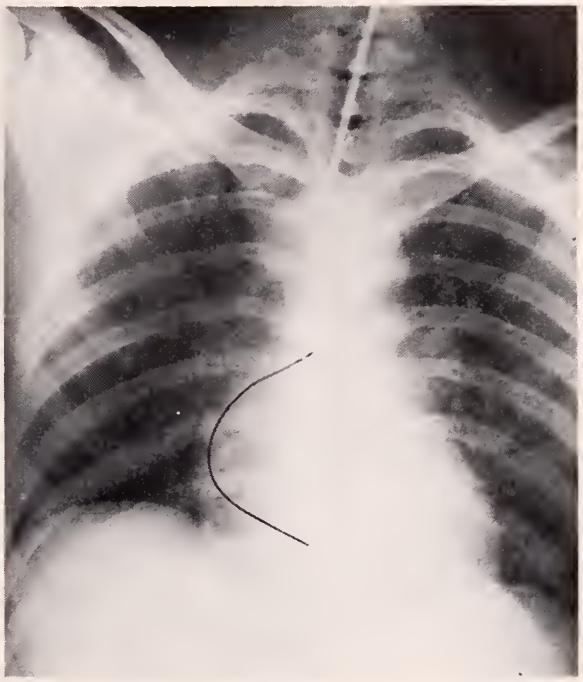

Fig. 3—The polyethylene catheter is transposed on the chest x-ray film to illustrate the complete removal.

Discussion

Complications in the use of indwelling polyethylene intravenous catheters are not rare. These may be divided into local and systemic. Bogen[1] reviewed the local complications in 167 patients. He found local pain, swelling, and phlebitis to be common and to increase with time. Indar[2] has described 10 cases of deep venous thrombosis at the insertion site. Tulgan and Budnitz[3] found a 74% incidence of phlebitis in catheters left in place 49 to 72 hours. Druskin and Seigel[4] found that 52% of all catheters left in place over 48 hours cultured positively for pathogenic organisms.

Systemic complications include sepsis and embolization. In 1954, Turner and Sommers[5] described the first case of catheter embolization to the heart. Since then, an additional 15 cases have been reported. To this we are adding 2 cases for a total of 17. Most catheters lodge in the annulus of the tricuspid

Fig. 4—Demonstrates a polyethylene catheter present in the markedly dilated heart of the patient in case 2.

TABLE 1—*Data of seventeen cases of catheter embolization to the heart*

Entry	Lodgement	Treatment	Result
Turner and Sommers, 1954[5]			
Median Cubital Vein	SVC, RA	None	Died, infarct myocardial necrosis and thrombosis
Brown and Kent, 1956[10]			
Femoral Vein	SVC, RA	None	Death, right ventricle perforation, tamponade
Ayers, 1957[13]			
Right Antecubital Vein	RA, RV	None	Death, bacterial endocarditis, septic pulmonary emboli
Trusler and Mustard, 1958[6]			
Median Cubital Vein	SVC, RA	Surgery	Successful
Barry et al, 1962[11]			
Right Brachial Vein	SVC, RA	None	Sudden death, infarction
Tulgan and Budnitz, 1963[3]			
Arm Vein	SVC, RA	None	Death, atrial fibrillation (11 months later)
Taylor and Rutherford, 1963[7]			
Arm Vein	? Heart	None	Asymptomatic
Steiner et al, 1965[14]			
Left Antecubital Vein	RA, RV	Surgery	Successful
Johnson, 1966[9]			
Antecubital Vein	RA, RV	None	Death, right atrial perforation, tamponade
Massumi and Ross, 1967[12]			
Subclavian Vein	SVC, RV	Nonsurgical removal	Successful
Doering et al, 1967[8]			
Cephalic Vein	RA	None	Death, right atrial perforation
Antecubital Vein	RV	Surgery	Successful
Antecubital Vein	RA	None	Asymptomatic
Antecubital Vein	RV	None	Death, unrelated disease
Antecubital Vein	RA	None	Death, shock, atrial fibrillation
Apfelberg et al, 1968			
Subclavian Vein	SVC, RA, RV	None	Death ? ?, unrelated
Antecubital Vein	RA, RV	Surgery	Successful

SVC = Superior vena cava.
RA = Right atrium.
RV = Right ventricle.

valve and trail into the superior vena cava.[6,7] Doering *et al*[8] described 3 cases where the catheter passed through the heart into the pulmonary artery. There is frequently local myocardial necrosis and mural thrombus at the catheter site. Perforation of the atrium may occur.[8-10] Other causes of death include infarction[5,11] and arrhythmias.[3,8]

Table 1 tabulates the 17 cases reported in the American literature according to site of entry, site of lodgement, treatment, and result. Thirteen catheters originally migrated from the antecubital area. Table 2 summarizes the data. Of 17 cases reported, 12 patients had no treatment. Eight patients (75%) died of directly related cardiopulmonary complications. Of the 5 patients who underwent surgical or nonsurgical[12] removal of the catheters, all are alive and asymptomatic.

Prevention and Treatment

To prevent the morbidity and mortality associated with embolization of plastic catheters to the heart, the following precautions have been suggested by Doering *et al*[8]: (1) The use of plastic catheters only in critically ill patients and those requiring prolonged intravenous therapy; (2) The use of radiopaque plastic catheters; (3) The measurement and recording of the length of the catheter before insertion; (4) Protection of the plastic tubing from the shearing force of the needle; (5) Avoidance of flexion areas such as the antecubital fossa; (6) Secure fixation to the skin; (7) Extreme caution in the restless patient.

The treatment of a missing catheter should be instituted immediately. A tourniquet should be placed around the upper arm and x-ray films of the arm and chest obtained. Local cutdown and removal of catheters still in the extremity should be done promptly. If the catheter has migrated to the heart, immediate surgical removal is indicated providing the patient's condition is stable. No fatalities or complications have been reported from such treatment.

TABLE 2—*Summary of data on seventeen cases of catheter embolization to the heart*

I. Total patients	17
II. No treatment	12
A. Deaths	10
1. Directly related cardiopulmonary	8
2. Unrelated	2
B. Asymptomatic	2
III Removal	5
A. Surgical	4
B. Nonsurgical	1
C. Alive, asymptomatic	5
D. Deaths	0
IV. Site of Entry	
A. Antecubital area	13

Summary

Extreme precaution and care must be observed in the use of indwelling intravenous polyethylene catheters. Untoward local complications, and death from systemic embolization may result from the careless use of such devices.

Adequate securing of the plastic part of the intracatheter is essential. The antecubital area should be avoided, especially in restless patients. Immediate surgical removal by cardiotomy is indicated for catheters in cardiac chambers. Five patients underwent successful removal without complications. Of 12 patients who had their catheters left in the heart, 8 died of direct cardiopulmonary complications.

It is hoped that this report may prevent further morbidity and mortality in the use of intravenous polyethylene catheters. □

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TRICHLORETHYLENE, TRILENE®, TRIMAR® ANALGESIA IN OBSTETRICS

Q ***Trichlorethylene analgesia via a Duke® inhaler is used for deliveries in our hospital. On occasion the nurse holds the mask, especially during the delivery and episiotomy repair. Is this safe?***

A Trichlorethylene, Trilene® and Trimar® are three names for the same chemical compound that is a useful analgesic drug in obstetrics.

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In the pamphlet that is enclosed with the drug by the makers of Trilene, the following statement appears in *capital letters and bold-faced type* in a separate *block* with the *underscored* heading, IMPORTANT—*TRILENE®* ALONE IS NOT RECOMMENDED FOR ANESTHESIA NOR THE INDUCTION OF ANESTHESIA. This statement is repeated in the text of the pamphlet, again in capital letters.

Clearly, the obstetrician should not request a nurse to hold or support the trichlorethylene inhaler for any patient. The nurse should refuse to apply the trichlorethylene inhaler to a patient, regardless of who issues the order.—WILLIAM KREUL, M.D.

Prepared at the request of the Maternal Mortality Study Committee of the Division on Maternal and Child Welfare of the Commission on State Departments of the State Medical Society of Wisconsin, and originally printed in the *Wisconsin Medical Journal,* April 1963, at page 203.

Therapeutic Dilemmas

No. 15 of a Series

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These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

"SCLERODERMA"

Moderator: GLENN H. FRANKE, M.D.
Participants: SAMUEL E. HOKE, M.D.
ERNEST BURNELL, M.D.
PHILIP B. O'NEILL, M.D.
GERSON C. BERNHARD, M.D.
GEORGE C. OWEN, M.D.
FREDERICK W. MADISON, M.D.

Dr. Glenn H. Franke: The entity which we are to consider is scleroderma, or progressive systemic sclerosis, the latter title being more satisfactory as indicative of the generalized nature of the malady rather than stressing the single dermatologic manifestation. Many of us have in fact accustomed ourselves to thinking of the term "scleroderma" in quotation marks. Doctor Hoke will present the protocol of our case.

Dr. Samuel E. Hoke (Resident in Medicine): A single, white 58-year-old woman, was admitted to this hospital on Dec. 22, 1967, having returned from a long residence in California a few months previously. The admitting complaints were cough, shortness of breath, and an elevated temperature—an acute situation that had arisen about 3 weeks before and become much exacerbated in the last 2 or 3 days. Progressive difficulty in breathing and swallowing, and a 22-lb weight loss over 3 or 4 months, were described. There had been a previous diagnosis of "scleroderma."

On physical examination her pulse and respiratory rates were 96 and 32 per minute, respectively, and her blood pressure was 102/52 mm Hg. The patient was very cachectic, and the skin was hard and stiff over the hands and face and taut and stiff over the abdomen. Rales were heard over the left lung field, but the right field was normal. A nodule was palpable in the right lobe of the thyroid.

A diagnosis of Raynaud's phenomenon in the hands had been made in 1945, when the patient was 35 years old. In 1947 there had been a thoracic sympathectomy, repeated in 1949. Tightness of the skin on the hands was first noted in 1954, at which time a course of corticosteroids was begun and continued for 1½ years; no drugs of this group have been taken since. There had been some general improvement during the years spent in California. The patient had smoked about 20 packs of cigarettes annually.

The laboratory findings upon admission were: hemoglobin, 9.4 gm; hematocrit, 32%; white blood cell count, 12,400; serum iron, 7 mcg/100 ml (normal: 75–175); iron-binding capacity, 254 mcg/100 ml (normal: 150–300); Coombs' and latex tests, negative. There were electrocardiographic changes consistent with chronic lung disease. The x-ray findings will be separately discussed. An upper gastrointestinal series demonstrated a general decrease in motility of the tract. A metastatic bone survey was negative.

A mass lesion of the right bronchus was observed on endoscopic examination, and biopsy of this region revealed malignancy.

In the hospital the patient has received antibiotics for the pneumonic process and is currently undergoing radiotherapy for the tumor.

Dr. Franke: The x-ray findings will now be presented.

Dr. Ernest Burnell (Resident in Radiology): The classic radiologic pulmonary findings in this malady are those of fine diffuse fibrotic changes in the lung fields, with a reticulated or multicystic pattern in 2% of the cases. This patient's findings depart somewhat from this, although we do have suggestion of diffuse, fine fibrosis on the left (Fig 1). There is mass density at the right base and a loss of volume on the right, indicative of atelectatic change. There is mediastinal shift toward the right. The heart size is not easily determinable because we can't really see the right border. We have evidence of the previous sympathectomies, with vascular clips at the apices and loss of the ribs posteriorly from surgery. Our film series, a very large one on this patient, began on Nov. 14, 1967, and continues through Jan. 15, 1968. On admission, Dec. 22, there was a fine patchy infiltrate involving the upper right lung field, but its subsequent clearing

indicated that this was a pneumonic rather than a metastatic process. However, an almost complete opacification of the right lung field has subsequently appeared and cleared again, indicating that there has been another pneumonic process. I shall show one film of the gastrointestinal series (Fig 2). One can appreciate very well here the esophageal dilatation, although in advanced "scleroderma" cases we usually see more of this. However, the fluoroscopist was aware of some impairment of esophageal motility.

The classic findings in the hands are those of osteolysis and loss of the distal phalangeal tufts. In our case (Fig 3) we have some evidence of osteolysis of the middle phalanx of the middle finger of the right hand and of the middle phalanx of the left index finger. There is tapering of the soft tissues distally at the fingertips and interstitial calcinosis in the soft tissues of the hand.

A Physician: Do I see some osteoporotic changes and narrowing of joint spaces and soft tissue swelling about the wrist?

Dr. Burnell: Some soft tissue swelling, yes; but I am not confident that there is narrowing of the joint spaces. Several areas of soft tissue calcification were observed in the axillae (Fig 4).

Dr. Franke: Thank you, Doctor Burnell. Doctor O'Neill has studied and written upon the gastrointestinal involvements in this disorder and will now discuss this aspect of the subject.

Dr. Philip B. O'Neill: The esophagus is the organ most likely to be involved: mucosal inflammation and thickening of the submucosa, erosion, ulceration, round-cell infiltration, muscle degeneration and atrophy. Since the proximal 3.9 cm of the esophagus have been shown usually to contain striated muscle, and striated muscle is uncommonly implicated in "scleroderma," there is rarely involvement of the upper end of the esophagus in the malady. Esophageal motility studies have shown weak or absent peristalsis. Acid reflux through an incompetent sphincteric mechanism in the lower esophagus is probably the cause of the reflux esophagitis. The patient experiences pyrosis, dysphagia, retrosternal pain and acid regurgitation, and frequently develops a hiatus hernia because of the short esophagus. It is interesting that of 9 patients in one series with Raynaud's phenomenon with unproved "scleroderma," 5 had decreased or no esoph-

Figure 1

Figure 2

Figure 3

Figure 4

ageal peristalsis. Figure 5 is typical of the widened esophagus with lack of tone in a patient with scleroderma.

The second gastrointestinal organ involved, but only half as frequently as the esophagus, is the upper small intestine. The patient develops segmental dilatation of the descending duodenum and jejunum with delayed intestinal transit time. The symptoms are intermittent abdominal pain, distention, borborygmus, with aggravation following eating, and relief after vomiting. There is often recurrent diarrhea and steatorrhea with bulky, malodorous, oily stools. The mucosa is intact, with collagen deposition in and around the lobules of Brunner's glands; there is also atrophy and fragmentation of the muscles, with collagen deposition therein. These patients may have defective absorption, particularly of xylose and vitamin B_{12}, the latter not improved after addition of the intrinsic factor. Bacterial utilization of the vitamin, rather than true malabsorption, is believed to underlie this defect. Other absorptive deficiencies, such as of calcium, carotene, prothrombin, are not seen consistently. Cultures from the area have shown proliferation of E. coli particularly, and it is probable that excessive bacterial fermentation contributes to the gastrointestinal distention. Peroral mucosal biopsy shows leafy type of villi, unlike that seen in celiac disease and tropical sprue, with lymphocytic infiltration and collagen deposition in the muscularis mucosae. In the x-ray picture (Fig 6) a characteristic sacculation with dilatation of the duodenal loop and superior jejunum is rather typical. Therapy with the broad-spectrum antibiotics, particularly alternating the tetracyclines and ampicillin, has effected temporary relief in some of these cases (I. J. Kahn et al., *New Eng. J. Med.* 274:1339, 1966).

The involvement in the stomach comprises edema, atrophy, and cellular infiltration, with disturbed motility and delayed emptying.

In the colon there is fibrous thickening of the submucosa with collagen replacement of smooth muscle, and the same x-ray evidence of sacculation as seen in the small intestine. Ulceration results from fibrosis around small arteries in contradistinction to the initial mucosal lesion with cryptic abscesses of ulcerative colitis. The picture in "scleroderma" is really that of advanced ulcerative colitis when fibrous replacement of the musculature has taken place.

Finally, Bartholomew and associates (L. G. Bartholomew et al., *A. J. Dig. Dis.* 9:43, 1964) at the Mayo Clinic found hepatic involvement in only 8 of their series of 727 cases, the findings in all instances being nonspecific. This having been verified elsewhere,

I think we can say that there is no typical lesion of "scleroderma" in the liver.

Dr. Franke: Thank you, Doctor O'Neill. Doctor Bernhard will now discuss the general and therapeutic aspects of "scleroderma."

Dr. Gerson C. Bernhard: The characteristic changes in this malady are inflammatory, fibrotic, and degenerative ones in the skin and internal organs, especially in the gastrointestinal tract, the heart, lungs, and kidneys. I really believe the title, progressive systemic sclerosis, is preferable because, while admittedly there are cases that always remain exclusively scleroderma, in the great majority of instances the disease truly becomes a progressive systemic one. As you undoubtedly know, there are about two females to every male affected. The most common age period is between 30 and 50 years, although cases are seen in older individuals and rarely ever in children.

This is not a new disease by any means, for very suggestive descriptions of at least the skin manifestations have come down to us from antiquity, and the name "scleroderma" was coined in 1847. In 1945, R. H. Goetz and M. B. Berne (*Mayo Clin. Proc.* 4: 337, 1945) introduced the more acceptable term, progressive systemic sclerosis.

A common initial symptom, which our patient this morning presented, is Raynaud's phenomenon. Then there is painless swelling and thickening of the skin, usually of the hands only at first, but later of the forearms, the face, the neck, and finally the chest and back. The lower extremities are almost never involved. About one-third of the patients present with rheumatic complaints and some have true polyarthritis that is difficult to distinguish clinically from rheumatoid disease. The course of this disease is chronic although there is a fulminating type among coal and gold miners and others considerably exposed to silica dust. There are commonly finger ulcerations with dissolution of bone, and about 10% of the patients have subcutaneous calcinosis. Other features are receding hairline and difficulty in chewing and swallowing because of the skin changes around the mouth. On biopsy of the skin one finds increased dermal collagen, thinning of the epidermis, loss of the rete pegs, atrophy of the dermal appendages, and hyalinization of arterioles.

Most of the patients complain of polyarthralgia sometime during their course, usually with stiffness and a diffuse thickening; commonly they present with hands that have stiff, painful, often very red and rather sausage-shaped fingers. A leathery crepitus or tendon friction rub over the joints frequently can be detected. The synovitis is characterized by an infiltrate of plasma cells and lymphocytes, and later an intense fibrosis.

Evidence of respiratory tract involvement in the disease is apparent by the common complaint of dyspnea, cough and recurrent infection. The pulmonary function problem presented is that of a stiff lung, or not uncommonly, alveolar capillary block. The presumable reason for this block is the widening of the basement membrane of the alveolar lining cells, as demonstrated in electron microscopy by Rodnan's group (R. S. Wilson, G. P. Rodnan and D. Robin, *Amer. J. Med.* 36:361, 1964).

The clinical manifestations of cardiac involvement depend upon the amount and location of the fibrosis within the myocardium. There are cases of pulmonary hypertension with increased pulmonary second sound, but cor pulmonale itself is uncommon. Left ventricular failure is observed more frequently than right. Most of the arrhythmias are supraventricular; bundle branch blocks, complete or incomplete, have been frequently described. Occasionally there are premature ventricular beats and ST and T wave changes. These patients apparently respond poorly to digitalis and easily develop its toxic effects.

The kidneys are involved to a significant degree. In Rodnan's (G. P. Rodnan, *Bull. Rheum. Dis.* 13, Feb., 1963) 100 patients reviewed, 21 of the 47 deaths were associated with renal disease. At necropsy the kidneys in these cases are virtually indistinguishable from those of malignant hypertension. Whether corticosteroid therapy is a precipitating factor to rapidly progressive nephropathy is undecided.

Occasional instances of neuropathy have been described, and a focal myositis in the striated musculature, not unlike that sometimes seen in rheumatoid disease or systemic lupus erythematosus, may be rarely encountered.

There is much question whether this disease belongs in the category of the diffuse

Figure 5

Figure 6

connective tissue inflammatory disorders or is truly a distinctive collagen disorder. You are aware of the considerable clinical overlap in these diseases. The observed immunologic abnormalities may relate directly to the pathogenesis of the disease or merely be secondary observations. The early vascular lesions are certainly inflammatory; later they become fibrotic. There is a suggestion of relationship of this disorder to others that are possibly of immunologic origin: Sjögren's syndrome, Hashimoto's thyroiditis, hypogammaglobulinemia. Between 22% and 41% of patients have been reported in various series as having positive tests for rheumatoid factor, apparently without correlation with the presence of synovitis. False positive serologies have been reported, but uncommonly. Immunofluorescent technics frequently reveal the presence of both antinuclear and antinucleolar serum factors. Serum complement levels are usually normal.

Surely this disease is suitably described as one presenting "therapeutic dilemmas," for there is really no drug or combination of drugs that is even fairly effective in prolonging life. Corticotropin (ACTH) and the corticosteroids will produce atrophy of dermal collagen bundles and disappearance of mucopolysaccharides in the skin, which will effect some relief of the skin lesions and the synovitis, but steroids have virtually no effect upon the visceral lesions that cause the fatalities. Relaxin, a human placental product, brings about some decrease in skin tightness, but this drug is expensive and also has no effect on the visceral lesions. EDTA had fairly extensive trial at one time, but is now rarely used. At the University of Michigan, C. J. D. Zarafonetis has been interested in the use of potassium paraminobenzoate (Potaba) and has reported (*Amer. J. Med. Sc.* 248:550, 1964) some improvement in skin softness under the drug, but again without effect on the visceral features of the disease. Sympathectomy, which is without effect on visceral involvement, can provide transient relief for the Raynaud manifestations. You will recall that our present patient underwent this operation twice. The use of penicillamine has been considered, for it will break sulfhydril bonds, and the polypeptide chains of collagen have sulfhydril linkages (E. D. Harris, Jr. and A. Sjoerdsma, *Lancet* 2:996, 1966); but my own small experience, and the larger experience of others, has not demonstrated clinical usefulness. Low molecular weight dextran is being tried currently by a few

investigators, with encouraging early results.

Supportive care is of course important. The patient fares much better in a warm than in a cold climate. Vasodilator measures may be helpful. Skin softeners should be used and detergents avoided. Physiotherapy and the use of analgesic drugs effect some relief of course in selected instances. Doctor O'Neill has fully covered the matter of esophageal involvement, but I would like to mention one patient of mine in whom irradiation of the stomach reduced acid production sufficiently to diminish strikingly the acidity of the esophageal reflux that was threatening to ulcerate her lower esophagus.

Although prediction of the course that progressive systemic sclerosis will take in the individual patient is not easy, the ultimate prognosis is definitely bad.

Dr. Franke: Thank you, Doctor Bernhard. Our patient this morning presented with carcinoma as well as the malady we have under more direct consideration. There is persistent rumor that an association exists between alveolar cell carcinoma of the lung and progressive systemic sclerosis. Doctor Owen, would you care to discuss this point?

Dr. George C. Owen: This impression stems from the report of Zarafonetis' group in Ann Arbor (J. Zatuchni, W. N. Campbell and C. J. D. Zarafonetis, *Cancer* 6:1146, 1953), who observed this association in 3 cases. Since that time the subject has been pursued of course, and as of two months ago, 11 such instances had been reported. In addition to these 11 cases in which the neoplasm was alveolar cell carcinoma of the lung, there have been 5 instances of adenocarcinoma and 2 of undifferentiated carcinoma. Our present patient has a large cell undifferentiated carcinoma of the bronchus, thus providing the third case of this type. The feeling of Weaver and associates, at the Mayo Clinic (A. L. Weaver, M. B. Divertie and J. L. Titus, *Mayo Cl. Proc.* 42:754, 1967), to whose recent review I am referring, was that the association between "scleroderma" and bronchogenic carcinoma or carcinoma of the lung in general is a fortuitous one rather than of the intimate nature of that between dermatomyositis and carcinoma anywhere in the body.

Dr. Franke: Thank you, Doctor Owen. Doctor Madison?

Dr. Frederick W. Madison: One of the interesting things about progressive systemic sclerosis is that we see a few patients whom we think may ultimately prove to be the unfortunate victims of this malady, but then as we watch them year after year nothing happens. At the moment we have 4 or 5 such cases under observation. The changes do not seem to go beyond swelling of the hands and minor alterations in the appearance of the skin. I wonder if Doctor Bernhard would care to comment upon instances of this sort and also to consider the question of whether it is not in these people particularly that the use of corticosteroids is questionably advisable?

Dr. Bernhard: I believe we must accustom ourselves to thinking of a spectrum of types and severities in this disease. At one end we could place the very fulminating cases in the miners, that I mentioned earlier, in which the sex incidence runs counter to that ordinarily seen, and then at the other end of this spectrum there would be such cases to which Doctor Madison refers. Perhaps the specific case we have considered this morning almost fits into this latter group; at least this patient has had a very long and initially benign course. There can certainly be fluctuations in the malady, and although the progression is likely to be rapid once visceral involvement has occurred, there is definite probability that published statistical studies have not taken into account the numerous very slowly progressing cases with skin involvement only. I recall a lady from my own practice in whom various therapies had been tried before she disappeared from follow-up, only to reappear 1½ years later in a much improved state—able to smile much better and with softer skin, and the like. When I asked how she had been able to obtain the drugs during all this time, she replied that she had long ago given up all that and simply relied on prayer!

No one can say with assurance that the use of corticosteroids plays a causative role in the development of the renal involvement, and in fact I find it difficult to understand how this could happen from what is known of the disorder and of the drugs. They may have been implicated falsely since they are reserved in the main for use late in the course of the more severe cases.

A Physician: In some cases, such as those referred to by Doctor Madison, in which the skin changes are not fully diagnostic, we

have found studies of esophageal function to be quite revealing.

Dr. Bernhard: I agree. There is not satisfactory statistical data regarding this because the sort of changes Doctor O'Neill pointed out to us earlier in this discussion have not been frequently demonstrated as yet, probably just because clinicians have not been requesting the studies from radiology departments. In fact, in Rodnan's series of 100 cases there were 4 or 5 in which there was visceral involvement alone without any skin changes at all.

Dr. Franke (summarizing): This morning we have discussed "scleroderma," or progressive systemic sclerosis, not only from the standpoint of the therapeutic difficulties it presents, but also with regard to its diagnostic and prognostic vagaries. The increasing knowledge of, and interest in, the systemic involvements in the disease have been particularly stressed. □

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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PART I: AURAL AGENTS

Topical Medication in Otolaryngology

By ROGER H. LEHMAN, M.D. and RICHARD I. H. WANG, Ph.D., M.D., Milwaukee, Wisconsin

■ SINCE AN IMPORTANT sector of clinical practice involves the treatment of otolaryngologic diseases, it is appropriate to select this topic for discussion. Treatment of otolaryngologic disease frequently requires the use of topical agents although they have restricted value.

Topical medication must be applied directly to the diseased area. It is explainable why the efficacy is limited. For example, in the ear they are often placed on a pool of exudate in the auditory canal; in the nose they are frequently expelled or quickly drained into the throat by gravity and the cilia action of the mucus blanket; in the oropharynx they are diluted by saliva and expectorated or swallowed.

Aural Agents

Absorption of medication from the intact skin of the auditory canal and tympanic membrane is limited when it is compared to the mucous membrane of nasopharynx. Medications with both aqueous and lipid solubility have greater penetrability.[1]

Solutions applied to the ear canal in drop form will not maintain contact with the diseased area unless the head is tilted and the canal is occluded by a cotton plug. A more effective method is to insert a pack or wick into the canal and soak it with the medication. Ointments should not be used on ulcerated surfaces because they prevent adequate drainage. However, they are indicated in dry crusted eruptions of the canal wall.

Analgesics and Anesthetics. The pain associated with acute ear disease may be severe. A topical anesthetic such as 5% lidocaine (Xylocaine) is indicated in diseases of the ear canal associated with itching or pain. Another preparation containing glycerin, antipyrine and benzocaine (Auralgan), is currently highly advertised. The rationale for the use of this preparation is the decongestant action of glycerin on the tympanic membrane and the anesthetic effects

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of benzocaine. Supplemental systemic medications are often necessary to provide better analgesia.

Cerumenolytics. There is a diversity of opinion regarding the efficacy of cerumenolytic agents. Warm water irrigation is effective for removing most cerumen. Hydrogen peroxide, glycerin, or a combination of the two will loosen impactions. The effervescent action of peroxide fragments cerumen and the emollient effect of glycerin softens the cerumen establishing thereby a cleavage plane between the impaction and the skin of the auditory canal. In recent years triethylanolamine polypeptide oleate-condensate (Cerumenex drops) has been advocated, but there is no advantage over hydrogen peroxide and glycerin. In difficult impactions, mechanical removal by curette, spoon, suction, or irrigation is necessary to cleanse adequately the ear canal, and the use of any cerumenolytic agent is considered only as adjunct therapy.

Antibiotics and Antiseptics. These are effective drugs in infections of the auditory canal and middle ear. If drainage is present, the canal and middle ear should be cleansed. Trauma is avoided by gentle manipulation of applicators and irrigators. Infections limited to the ear canal are of mixed bacterial origin. Superficial lesions are commonly due to the gram-negative Pseudomonas aeruginosa, and deeper involvement with microabscesses is associated with the gram-positive Staphylococcus aureus. Five percent acetic acid is effective against these pathogens.[2] Aluminum acetate solution buffered to a pH of 5.0 is another astringent, anti-inflammatory, and anti-pruritic agent that has proved to be of value in external otitis of allergic or contact origin. Colistin sulfate (Colymycin), neomycin, and polymyxin B are the preferred topical antibiotics in ear disease. Tetracycline (Achromycin), erythromycin (Ilotycin), and oxytetracycline (Terramycin) are also available in topical otic forms. In general, the topical agents are recommended over those systemic antibiotics.

Steroids. Topical steroids are indicated in subacute and chronic forms of external otitis where ulceration and granulation are present. Hydrocortisone and prednisolone are available as otic preparations. The resolution of the inflammatory reaction may be prompt. The use of steroids is contraindicated in tuberculosis, herpes simplex, vaccinia, varicella, and fungus infections.

Enzymes. Enzymes have been used in the ear to depolymerize inflammatory exudates. With the elimination of the fibrin barrier and resorption of edema, topical antibacterial agents would be more effective. The rationale for the use of these drugs is acceptable, but well controlled studies demonstrating their efficacy are lacking.

Therapy for the Middle Ear. Topical medication has a definite place in the management of chronic otitis media. Preoperative medical management will decrease the inflammatory reaction and favorably influence its outcome when reconstructive middle ear surgery is needed. In marginal tympanic membrane perforations with evidence of cholesteatoma there is usually minimal suppuration, and surgery is the primary form of treatment. Since the anatomical ramifications of the middle ear cavity prevent the accessibility of topical medication to the diseased ear, local cleansing measures utilizing irrigation and suction prior to instillation of topical medication are necessary.

For otitis media both wet and dry forms of treatment have been popular. The wet treatment is preferred during the active stage of exudation. The liquid medication is instilled into the auditory canal with the head placed on the opposite shoulder. This position should be maintained for a few moments to allow movement of the drug through the canal and tympanic membrane perforation into the middle ear. Gentle positive and negative pressure applied to the canal through a closed otoscope will mobilize the exudate and bring the medication in contact with the recessed areas of the middle ear cavity.

Glycerite of hydrogen peroxide is an effective drug with antibacterial and effervescent action. Boric acid and alcohol has antiseptic, astringent, and dehydrating properties. Nitrofurazone (Furacin) is active against a variety of gram-positive and gram-negative organisms.

Colistin sulfate (Colymycin), neomycin, and polymyxin are effective antibiotics in the treatment of chronic infections with mixed bacterial flora. Local sensitivity to neomycin is occasionally encountered. It has been characterized by an exacerbation of the inflammatory reaction with congestion, drainage,

and eosinophilia. Steroids are of value in the treatment of chronic suppurative otitis media when granulation tissue is present. Hydrocortisone and prednisolone may both resolve granulations and minimize further destruction of middle ear mucous membrane and ossicles.

The dry treatment has had its advocates for many years. The rationale is that moisture favors bacterial growth. It is most applicable for diseases with minimal exudation. The powder form of boric acid, iodine, sulfonamides, antibiotics, and fungicides have been used. They are applied to the auditory canal and middle ear by an insufflator. Excessive amounts of these agents may cause concretions in the tympanic and mastoid cavities.

Silver nitrate and chromic acid in the form of solid beads on applicators are topical escharotics occasionally indicated in the middle ear to eliminate granulation. Trichloroacetic acid solution in 33% to 50% concentration is equally effective when applied to a cotton-tipped applicator. A number of treatments may be necessary to achieve the desired result. *(Continued next month)*

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OBSTETRICAL BRIEF

MOTHER AND CHILD—Labor and Analgesia

By WILLIAM KREUL, M.D., Racine, Wisconsin

OBSTETRICIANS regularly remind themselves and others that the pregnant woman is a special problem because her unborn child must be considered in all dealings with her. During the throes of labor this fact introduces additional implications because the needs of the child are diametrically opposed to those of the mother. She needs pain relief, sedation, and quieting of her fears. The unborn child needs at least not to be depressed and may require stimulation at the time of birth to initiate breathing and establish adequate homeostasis.

Pain is a usual byproduct of the uterine contractions of labor. In this, as in all other pain situations, individual appreciation, interpretation, and response varies widely. In addition to pain, anxiety with an uneasiness of mind and an impatience for completion attends labor in varying degrees. Fear, sometimes unfounded or poorly understood, may occupy much of the emotional content of labor. These three are not independent entities.

Pain is a very personal subjective experience. Pain is enhanced by worry, resentment, fear, anxiety, anger, apprehension. The anxious and fearful patient feels pain more acutely. Treat the anxiety and analgesic requirements will be less. Pain tends to produce or accentuate anxiety. Treat the pain and the anxiety will be less. The goal is to prescribe analgesics (morphine, meperidine, and the like), sedatives (barbiturates, and the like) and minor tranquilizers (hydroxyzine, promethazine, and the like) the amount of each in proportion to the individual's need at a given time.

Inappropriate drug and dose is an ever present threat. When analgesics are used to control apprehension, respiratory depression is excessive. When sedatives and hypnotics are used to control pain, cerebral and cardiovascular depression becomes inordinate. Minimize the total depressant effect by administering the appropriate drug, and dose of the drug chosen, to control the symptoms, analgesic for pain, sedative for rest, tranquilizer for apprehension and fear. Combinations will be necessary in most patients but individualization is essential.

All analgesic, sedative, and tranquilizing drugs are depressing. The total depressant effect of all that are administered should be considered in the welfare of the unborn child. The best interest of mother and child are opposed. The mother needs the help these depressing drugs offer, but the infant needs stimulation rather than depression. The mother is entitled to help but not to the point of jeopardy to her child. Nor does she need that degree of drugging. Unless her voluntary control is completely removed by drugs, she can withstand or put up with a significant part of her pain and discomfort.

Knowledge of the patient historically in prior deliveries and her response in other pain and emotional situations can help gauge doses. Dose requirement of each drug may be expected to be less than average when combinations are used. Balanced therapeusis is physiologic and scientific but becomes "shotgun" medicine when every patient receives the same combination of drugs in the same doses.

P.S.—Liberal doses of T.L.C. (tender loving care) should be given by the obstetrician and his nursing staff. Depression does not accompany its use. Excessive doses are difficult if not impossible to administer. T.L.C. saves on drugs. □

Doctor Kreul is an anesthesiologist.

W. D. James, M.D.

PRESIDENT'S PAGE

"You," The Government

A GOOD DEAL OF PUBLICITY has generated from the anticipated deficit in the budget of the State of Wisconsin and a large part of the blame is being laid to Medicaid costs.

In a frantic effort to "do something" about these costs, our government seems reluctant to face an inescapable fact: Ever increasing numbers of persons are accepting the benefits committed to them by our legislature when it adopted Medicaid. Instead, there are proposals to eliminate "free choice," to limit utilization of services, and to eliminate payment of "usual, customary and reasonable" charges for professional services.

I suggest that "you" (our government) consider the potential effect of such proposals:

"You" would declare that the poor and the impoverished ill and injured should receive a different type of treatment than do the self-supporting.

"You" are substituting administrative rule for medical judgment in determining whom a sick person should see for health care and what kind of treatment he needs.

"You" are setting a health-care budget and forcing the sick and injured poor to try to stay alive within it.

Despite the potentially dangerous consequences, "you" are, in effect, demanding underutilization of health services by the poor.

The medical profession realizes full well the need to deliver high quality medical care to all in our state, including the poor. By effectively applying peer review of physicians' charges and carefully scrutinizing utilization practices, we are doing our part to make this a reality.

I believe that the people of Wisconsin want the poor to receive the same quality of health care as those who are able to pay their own way.

I urge that "you," the government, in no way jeopardize the care of the impoverished ill by regulations which in their long-term effect can only dilute the quality of medical service to the poor.

W. D. James M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Slow Progress Report

■ THE BATTLE AGAINST cigarette smoking seems to be turning against the cigarette manufacturers at long last. For the first time since 1964, according to a report in the December 21 issue of *Business Week*, cigarette sales in 1968 fell below those of the preceding year. Sales of 526.5 billion cigarettes were reported for 1968, 1.3 billion less than were sold in 1967.

Interestingly, reduced sales of nonfilter cigarettes accounted for most of the decrease.

The cigarette manufacturers are under no delusion as to what caused the sales decline. In June 1967, the Federal Communications Commission ruled that broadcasters who carry cigarette advertising must, under the so-called equal time doctrine, carry announcements which describe the perils of cigarette smoking. In the three years prior, the American Cancer Society had distributed less than 1,000 film prints to TV stations. Most of these were characterized by a rather wistful, soft-sell approach.

In the nine-month period following the FCC ruling, more than 4,700 prints were distributed to television broadcasters, and these were of markedly improved quality. In all of 1967, the three major networks aired about 100 "spots." In the first four months of 1968, more than 200 announcements were broadcast, reaching a total of about 600 by the end of the year.

In addition to a stepped up volume of messages, the anti-smoking television commercials began to hit harder. They have become clever, pointed, and slick enough to counteract the professionalism of the highly skilled pro-smoke messages. In fact, it is reported, some stations found some of the commercials so powerful that they steered away from broadcasting them and accepted others less forceful.

The results are good news for those concerned with the hazards of cigarette smoking, and equally disturbing to those whose investment depends on an ever-increasing smoking public. Studies quoted by *Business Week* and investigations made by the American Cancer Society indicate that the percentage of males who smoke is now slightly higher than 40%, down from a high of 55% in 1958. The proportion of smokers in the 21 to 24 year age group is down to 47% (from 52% in 1960); in the 25 to 34 year

age group the percentage of smokers is down to 45%, and in the 35 to 49 year group the percentage has dropped 4%, to 44%.

At the present time there are about 70 million cigarette smokers in the United States, 85% of whom, according to an ACS report, want to quit. About 21 million have already made at least one try at discontinuing the habit. There were about 2 million fewer pack-a-day smokers in 1968 than there were in 1967, and the per capita consumption of cigarettes went down about 2%.

Although *Business Week* and others attribute the sales slippage to negative publicity, it is also true that the cigarette industry is prevented from actively promoting the habit, except indirectly. No television or radio commercial or cigarette ad in a print medium can suggest that cigarette smoking is not harmful, so as to negate the message of the Cancer Society. At the present time there is an effort in progress to ban cigarette advertising of all kinds, as it is in England, but the success of such an attempt is considered doubtful in this country.

The American Cancer Society is to be congratulated on its endeavors in this area. It seems clear that the result that was not accomplished by the Surgeon General's report on smoking can be attained only through the same methods that sold the American public on the habit in the first place. Social custom, movies, TV programs, and precedence give the cigarette manufacturers a great advantage, and it is obviously going to require a long, unrelenting system of counter-publicity to save the American public from itself.

The work should be done, and the American Cancer Society should have all the help it can get. Over 100,000 doctors themselves have seen the light in the last year, according to reports, and perhaps more will kick the habit in 1969. But whether he indulges or not, every doctor should emphasize to his patients the health hazard of smoking and the advantages of breaking the habit. At the same time, all the media that influence the formation of social habits should be encouraged to deemphasize the use of cigarettes.

It is perhaps unrealistic to anticipate the total elimination of cigarette smoking, but it is to be hoped that with all elements interested in health care working together, the proportion of the population that does smoke will be reduced to an absolute minimum.

—DNG

LETTERS

HELP URGED FOR PRODUCT SAFETY STUDY

To the EDITOR:

I write you in an effort to inform my colleagues through your publication of an important fact-finding mission I am currently engaged in and to alert them to expect to hear from me personally.

I have taken a year's leave of absence from my private practice in New Jersey to serve with a fact-finding agency of government known as the National Commission on Product Safety. This Commission was established by Congress to develop effective means to protect Americans from unreasonable hazards related to many products commonly used in and around the home today. In addition to funding this Commission, Congress has granted us adequate powers to conduct this study.

Every physician in the country—as a consumer—will benefit from the work of this Commission. So will his family, his patients, and all Americans.

I plan to contact "front line" physicians—those dedicated and competent individuals who get the calls and see the victims of accident injuries—in a nationwide survey of product-related accidents. A questionnaire will be mailed to the medical profession's "front liners" during the month of March. The questionnaire will seek to elicit information on all product-related injuries treated during the first two weeks in April.

The last ten years have seen a rising tide of interest in and legislation for prolonging American lives, ranging from better automobile design to warnings against smoking. The National Commission on Product Safety's work is directed toward household product safety.

I am counting on the wholehearted cooperation of the medical profession for the priceless information that only physicians can make available to this Commission.

SAMUEL C. SOUTHARD, MD, FAAP
Director, Task Force I
National Commission on Product Safety
1016 16th Street N. W.
Washington, D. C. 20036

SECTION

OPHTHALMOLOGY

FEBRUARY 1969

EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

MARQUETTE GIVEN $600,000 FOR EYE INSTITUTE

Building of an eye institute as part of the proposed southeastern Wisconsin medical center was assured early in January when Marquette School of Medicine received two gifts totaling $600,000 for that purpose.

With development of the institute, Milwaukee will become one of 13 cities in the country to have an eye institute, according to Louis Quarles, president of the medical school board.

The institute, which will be located on the Milwaukee county institutions grounds in Wauwatosa, will enable the medical school's eye department to expand medical research programs and increase its services to patients with eye diseases, according to Dr. Richard O. Schultz, professor and chairman of the eye department.

The department treats about 30,000 eye patients annually, performing more than 700 surgical operations. Of 167 U. S. programs for training eye physicians, the Marquette department's program is ranked the ninth largest.

The gifts included $400,000 donated by the trustees of the Faye McBeath Foundation of Milwaukee and $200,000 given by an anonymous donor in honor of the late Dr. Clemens C. Messmer, an eye specialist who practiced in Milwaukee from 1907 until his death 10 years ago.

The two gifts will establish the Messmer Memorial Eye Clinic and Center for Clinical Research and the Faye McBeath Eye Research Institute.

NEW OPHTHALMOLOGIST IN MADISON

Dr. William E. Meisekothen has opened an office in Madison to practice ophthalmology. Doctor Meisekothen finished his residency at the University of Wisconsin Hospitals in December 1968. He was in general practice in Madison at the East Madison Clinic for 12 years prior to his residency. He is a graduate of Loyola Medical School.

PIONEER LAW ON EYEGLASS SAFETY

The nation's first legislation making it a crime to dispense eyeglasses that are not made with safety lenses has been enacted by Alaska, where occupational trauma is a leading medical problem. The statute . . . specifies that lenses must be made of plastic or of tempered glass two millimeters thick. Frames must be nonflammable. Calling the law "one of the most progressive steps ever taken to protect the eyesight of the millions who wear glasses," Dr. John W. Ferree, executive director of the National Society for the Prevention of Blindness, hopes that it will set the trend for the entire U.S.—MEDICAL WORLD NEWS, Dec. 13, 1968

DR. ROSSMAN JOINS WAUSAU CLINIC

Dr. Lawrence J. Rossman recently joined the Backer Eye Clinic of Wausau. He is a 1961 graduate of Marquette University School of Medicine and interned at St. Mary's Hospital in Duluth, Minn. He returned to Marquette for his ophthalmology residency in association with the VA Hospital and Milwaukee County General Hospital.

NEW OPHTHALMOLOGIST AT DEAN CLINIC

Dr. Charles E. Nahn has joined the staff of the Dean Clinic, Madison, in the practice of ophthalmology. He is a 1959 graduate of Marquette University School of Medicine. His internship was taken at St. Mary's Hospital, Grand Rapids, Mich., and his residency training at Letterman General Hospital, San Francisco, Calif.

DR. BOLGER NAMED TO NATIONAL BOARD

Dr. James V. Bolger, Jr., of Waukesha has been elected to a three-year term on the Board of Trustees of the American Association of Ophthalmology. He is active in many civic and medical groups in Wisconsin, most recently having been chairman of the Section on Ophthalmology of the State Medical Society.

HAVE YOU PAID YOUR DUES?

One ophthalmologist who recently sent $100 for his voluntary dues to the Section made this comment: The ophthalmology page in the State Medical Journal is excellent, keep up with the good work.

How about you? Have you paid your dues? Response has been excellent but we need 100% participation. Checks are payable to: Section on Ophthalmology. Mail to: State Medical Society, Box 1109, Madison, Wis. 53701.

MEETING DATES

Mar. 25: Milwaukee Ophthalmological Society, University Club of Milwaukee, 6:00 P.M.

May 14–16: Annual Conference, National Society for the Prevention of Blindness, Pfister Hotel, Milwaukee.

May 15: Annual meeting, Section on Ophthalmology, Hotel Sheraton–Schroeder, Milwaukee, in conjunction with the State Medical Society annual meeting.

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THE CHOLEDOCHAL CYST

Surgical Aspects and Management

By JOHN T. GOSWITZ, M.D., Manitowoc, Wisconsin

■ CONGENITAL CYSTIC dilatation of the common bile duct, also known as the choledochal cyst, is a rare disease which can lead to tragic debility if not adequately treated. The rarity of the condition has prevented the accumulation of a large series of cases which would allow careful analysis of diagnosis and treatment. Undoubtedly, this has contributed to some confusion in treatment.

The etiology of the cyst is believed to be a congenital weakness of the common duct wall coupled with an obstructive element in the distal common duct. Obstruction to biliary outflow leads to increased pressure within the duct which, in turn, leads to progressive aneurysmal dilatation at the weakest point in the duct.[1] The eventual diameter of the cyst usually reaches several centimeters.

Classically, the diagnosis is dependent on the clinical triad of abdominal mass, pain, and jaundice. In his review of 52 cases, Gross[1] has reported the occurrence of pain in 63%, tumor in 87%, and jaundice in 83%. However, the pain may be intermittent, and the mass may not be palpable. Indeed, the sequence of occurrence of pain, tumor, and jaundice may vary; one or two may be present for a period of time before the others become evident. Simple awareness of the condition is probably the most important aspect of making the diagnosis.[2] The disease usually makes itself apparent during the first and second year of life.

Radiologic diagnosis involves visualization of a soft tissue mass, duodenal impression on barium meal, and nonvisualization of the gallbladder.[3] If the bilirubin levels are normal, intravenous cholecystography may be diagnostic.

Pathologically, the common duct above the duodenum is involved. The cystic dilatation does not usually extend into the distal duct, and the pancreatic duct is rarely involved. Patency of the distal common duct can be demonstrated with probes, but a true obstruction to outflow from the cyst does exist.

Adequate treatment depends on drainage of the cyst into the gastrointestinal tract. This is best accomplished by either the Roux-en-Y jejunal anastomosis or the direct choledochocystoduodenostomy. No other form of therapy appears to have any affect on the ascending cholangitis and biliary cirrhosis which will be certain to follow unless the cyst itself is well drained.[4]

Two recent patients with choledochal cysts illustrate the problems and reaffirm the necessity of adequate drainage of the cyst before the symptoms can be alleviated.

Case Reports

Case 1. This nine-month-old female was admitted to the hospital with a four-day history of progressive anorexia and vomiting. Physical examination showed a well developed female baby with a weight of 14 lb, 3 oz, temperature of 101 F, and no evidence of jaundice. The abdomen was distended, silent, and produced extreme irritability when touched. Positive laboratory tests included: a white blood cell count of 30,300 per cu mm with a marked left shift, a carbon dioxide content of 18.4 mEq/liter, and moderate bile in the urine.

The patient was prepared with fluids and taken to surgery on the day of admission. At laparotomy a perforated choledochal cyst was found. The gallbladder was removed and the cystic duct was used as a flap to close the perforation around a t-tube placed in the cyst.

Reprint requests to: John T. Goswitz, M.D., Park Medical Center, 601 No. 8th Street, Manitowoc, Wis. 54220.

Bile cultures, taken at surgery and again 4 days after surgery, were sterile. On the 7th day, antibiotics (penicillin and chloramphenicol) were discontinued. The postoperative course was uneventful until the 10th postoperative day when the t-tube, which had been on gravity drainage, was elevated to reduce the loss of bile. Shortly, the patient developed anorexia, fever, and elevated white blood cell count. These findings disappeared when the t-tube was lowered again to gravity drainage. A bile culture at this time grew out Escherichia coli. Similar episodes occurred on two subsequent occasions in the next three weeks. Each time the t-tube was either clamped or elevated so that drainage from the cyst was obstructed, ascending cholangitis occurred. On the 33rd postoperative day, choledochocystoduodenostomy was performed. The patient's condition has remained good since the second operation.

Case 2. During the first three years of this male's life, he experienced periodic episodes of severe, colicky pain, vomiting, fever, and diarrhea. After four hospital admissions for these problems and at the age of three and one-half years, a cholecystogram showed a mass believed to be a choledochal cyst. At that time, a cholecystoduodenostomy was performed.[5]

Within three weeks after this procedure, the patient again began to experience periodic episodes of colicky pain, fever, and diarrhea. These would occur on the average of one a week and last from five minutes to several hours. At no time was there evidence of jaundice. The alkaline phosphatase remained elevated at 8.7 mg/100 ml (1.0 to 4.0 mg/100 ml normal). Four subsequent hospital admissions showed persistent temperature elevations and minimal, but persistent, elevations of SGOT, SGPT, and alkaline phosphatase.

At the age of six and one-half years, the patient was admitted to the hospital with an acute surgical abdomen, fever, and anorexia. Emergency laparotomy showed widespread mesenteric adenitis secondary to ascending cholangitis. The cholecystoduodenostomy appeared to be patent and was not disturbed. A choledochocystoduodenostomy, liver biopsy, and bile culture were done. The bile cultures grew out Proteus and Aerobacter organisms, and the liver biopsy showed evidence of very early portal cirrhosis. His postoperative course was completely benign, and in the 18 months since this procedure, he has been asymptomatic. His alkaline phosphatase has fallen to 5.5 mg/100 ml. Repeat upper gastrointestinal examinations continue to show free reflux of barium into the choledochal cyst.

Discussion

These two cases illustrate the necessity of adequate drainage of choledochal cysts. In the first patient, pressure necrosis was probably the cause of the perforation. The t-tube inserted at surgery served as a safety valve and allowed free flow-out of the cyst as long as this tube remained on gravity drainage. Each time the tube was elevated or clamped, the cyst became a stagnant culture pool and ascending cholangitis occurred. It is interesting to note that the bile cultures were sterile until the 4th postoperative day. On the 7th postoperative day, antibiotics were discontinued, and on the 10th postoperative day, Escherichia coli was cultured from the bile. Once the cyst was adequately drained by a choledochocystoduodenostomy, no further difficulties occurred.

The second case illustrates the varied problems encountered in these patients. Once the diagnosis was made, a procedure other than cholecystoduodenostomy should have been performed. The valves of Heister probably prevent this type of anastomosis from relieving the obstructed biliary tract. Three years of recurrent symptoms then followed the first operation until choledochocystoduodenostomy completely relieved the patient's problems.

The choledochocystoduodenostomy and the Roux-en-Y anastomosis appear to be the only types of internal drain which can relieve the symptoms of these patients. Reflux ascending cholangitis appears to be a problem only when an obstructive element remains in the biliary tract.[6] Free reflux from the gastrointestinal tract into the biliary system should cause no difficulty as long as there is free reflux back from the biliary system into the gastrointestinal tract. As long as the anastomosis remains freely patent, there should be no difficulty with ascending cholangitis. Antibiotics may help to reduce the number or severity of the attacks of cholangitis, but they seem to be no substitute for adequate drainage of the biliary system.[7]

The importance of bile cultures and liver biopsies in these cases cannot be overemphasized.

Summary

Two cases are presented illustrating the importance of adequate drainage of the choledochal cyst into the gastrointestinal tract. Once such drainage has been established, the symptoms associated with the choledochal cyst are alleviated. □

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Cerebral Angiomatous Malformations with Misleading Manifestations

Report of Three Cases with Surgical Cure

By BAHIJ S. SALIBI, M.D., Marshfield, Wisconsin

■ DESPITE THE GREAT VALUE of serial angiography in the diagnosis of cerebral angiomatous malformations, the latter may still be missed even with this technique.[1, 2] Clinical diagnosis may also be difficult. With relatively slow bleeding, local cerebral irritation, or shunting of blood away from other areas of the brain, a wide variety of often misleading clinical manifestations may occur, and may be severely disabling. A plea is made to include such lesions in the differential diagnosis of almost any serious cerebral disorder, especially as their surgical correction is becoming increasingly satisfying.

In two of the following three cases, the diagnosis was not recognized until surgery, despite preoperative serial angiography. In the third case, the lesion was correctly diagnosed by angiography, but its clinical localization was in the left frontotemporal region 5 to 7 cm from its actual location above the left frontal pole of the brain. In all three cases, surgical treatment resulted in a complete and apparently permanent cure, with a follow-up of about nine, eight, and three years respectively.

Case Reports

Case 1. A 50-year-old male factory worker had a sudden onset of left hemiplegia, nausea, and slurring of speech, on Nov. 24, 1958, followed by slow improvement. There was also a four-year history of a left parkinsonian tremor. Physical examination revealed a left hemiparesis, an increase in the muscle-stretch reflexes on the left side, a left extensor plantar response, and a left unsustained ankle clonus. Roentgenograms of the head and chest were normal. On lumbar puncture, the cerebrospinal fluid (CSF) was colorless and acellular, with a mildly elevated pressure of 198 mm of CSF, and a normal protein content of 31 mg/100 ml.

A serial right carotid angiogram the next day was within normal limits. However, in the lateral view of the arterial phase (Fig 1a), there was a possible mild ventral bowing of the proximal portion of the anterior cerebral artery along the lamina terminalis, remotely suggesting a mass or dilatation in the third ventricle.

Three days later an air ventriculogram with laminography showed a vertically elongated mass, 3.3 x 1.3 cm, in the anterior horn of the right lateral ventricle, possibly involving the third ventricle and foramen of Monro (Fig 1b). An area of mild porencephaly was noted anteriorly and inferiorly to the mass.

A right parasagittal craniotomy was performed on Dec. 1, 1958. With limited splitting of the corpus callosum and septum pellucidum, both lateral ventricles were exposed over the foramen of Monro. A dark, reddish-gray, angiomatous malformation was found in the right lateral ventricle, foramen of Monro and third ventricle, apparently associated with the choroid plexus and with a large nutrient vessel in the right lateral ventricle. Silver clips were applied to the nutrient vessel, whereupon the malformation collapsed and became blanched. No attempt was made to remove the lesion because of its deep extension into the third ventricle. The positions of the bone flap and silver clips are shown on the follow-up skull films (Figs 1c and d).

The patient recovered consciousness promptly after termination of the anesthetic and walked without support on the second postoperative day. Ten days later, he developed a widespread urticarial rash, followed by a mild psychosis.

The left parkinsonian tremor, hemiparesis, and psychosis gradually cleared within two to three months, and have not recurred. The patient returned to full-time work about four months after surgery. He was last seen in follow-up in June 1967, last heard from in January 1968, and has been asymptomatic and working steadily since April 1959. The only residual neurological deficit noted on his last examination was an extensor plantar response on the left.

Case 2. A 20-year-old male freshman college student was admitted to the hospital on Feb. 2, 1960, with a three-week history of progressive headache, vomiting, and deterioration in consciousness. On admission, he was prostrate, confused and incontinent. There was a marked left hemiparesis, incoordination, and loss of position sense, with a strong left extensor plantar response. Early papilledema and small hemorrhages were noted on funduscopic examination. Roentgenograms of the head and chest were normal except for some prominence of the right cranial vascular markings.

Serial right carotid angiography the next day showed a marked leftward displacement of the anterior cerebral artery (Fig 2a) and internal cerebral vein 14 mm and 18 mm, respectively. There was also a marked upward arching of the right middle cerebral artery over a large avascular area in the right temporal and lower parietal regions (Fig 2b).

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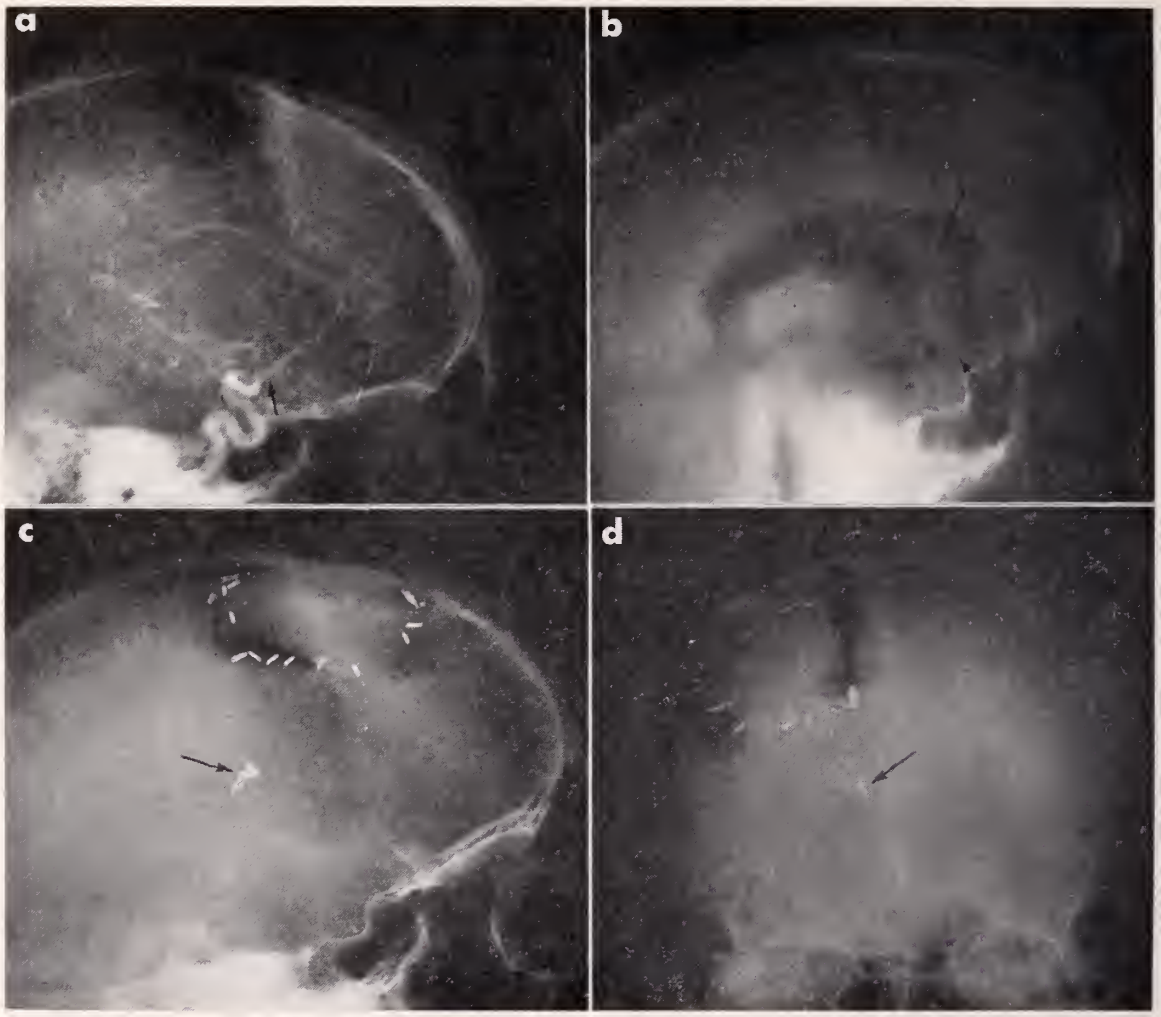

Fig. 1 (Case 1)—(a) Right carotid angiogram, lateral view of arterial phase: There is a suggestion of minimal ventral bowing (arrow) of the anterior cerebral artery along the lamina terminalis, which may indicate a dilatation or mass in the third ventricle, or may be within normal limits. (b) Air ventriculogram: Lateral laminogram film taken through a plain 0.5 to 1.0 cm to the right of the mid-sagittal plain, with the patient's right side up. A mass (arrows) is noted in the anterior horn of the right lateral ventricle, with possible involvement of the third ventricle, and with some adjacent porencephaly anteriorly and inferiorly. (c, d) Follow-up roentgenograms taken seven years postoperatively. Arrows indicate the metal clips which were applied to the nutrient artery of the angiomatous malformation, in the right lateral ventricle. The other hemostatic clips, immediately beneath the bone flap, were applied to the dura which was unusually vascular. Incidentally noted is some osseous resorption in the bone flap, but the latter is clinically solid.

A right temporoparietal craniotomy was performed the following day. A large, multilocular, cystic mass was found, containing dark red and greenish-brown fluid. The fluid was aspirated, and the lesion was completely excised by careful dissection around its walls. In many areas necrotic brain tissue surrounded the greenish-brown wall of the lesion, and this also was removed. The patient did well postoperatively, and a follow-up angiogram showed complete return of the displaced vessels to their normal position and configuration (Figs 2c and d).

Histologically, the specimen consisted of an angiomatous malformation with old and recent hemorrhage and thrombosis (Figs 3a and b).

The patient was discharged from the hospital 16 days postoperatively, with no demonstrable neurological deficit. He continued his education and became a nurse anesthetist with a busy practice, comfortably supporting his wife and two children. He was last examined in January 1966, and last heard from in July 1968. His only remaining symptoms are occasional headaches when he is under strain.

Case 3. A 26-year-old laborer had a gradual onset of severe left frontal headache in late May 1965. He recovered after a week and returned to work. A month later the headache recurred for a few days but was relatively mild. While at work, on July 20, 1965, the patient had a generalized convulsive seizure, with unconsciousness lasting 15 minutes. The following day he had four seizures, in only two of which he lost consciousness. In the other two, he merely became aphasic, and the right side of his mouth was drawn. He was hospitalized by his local physician and started on 30 mg of pheno-

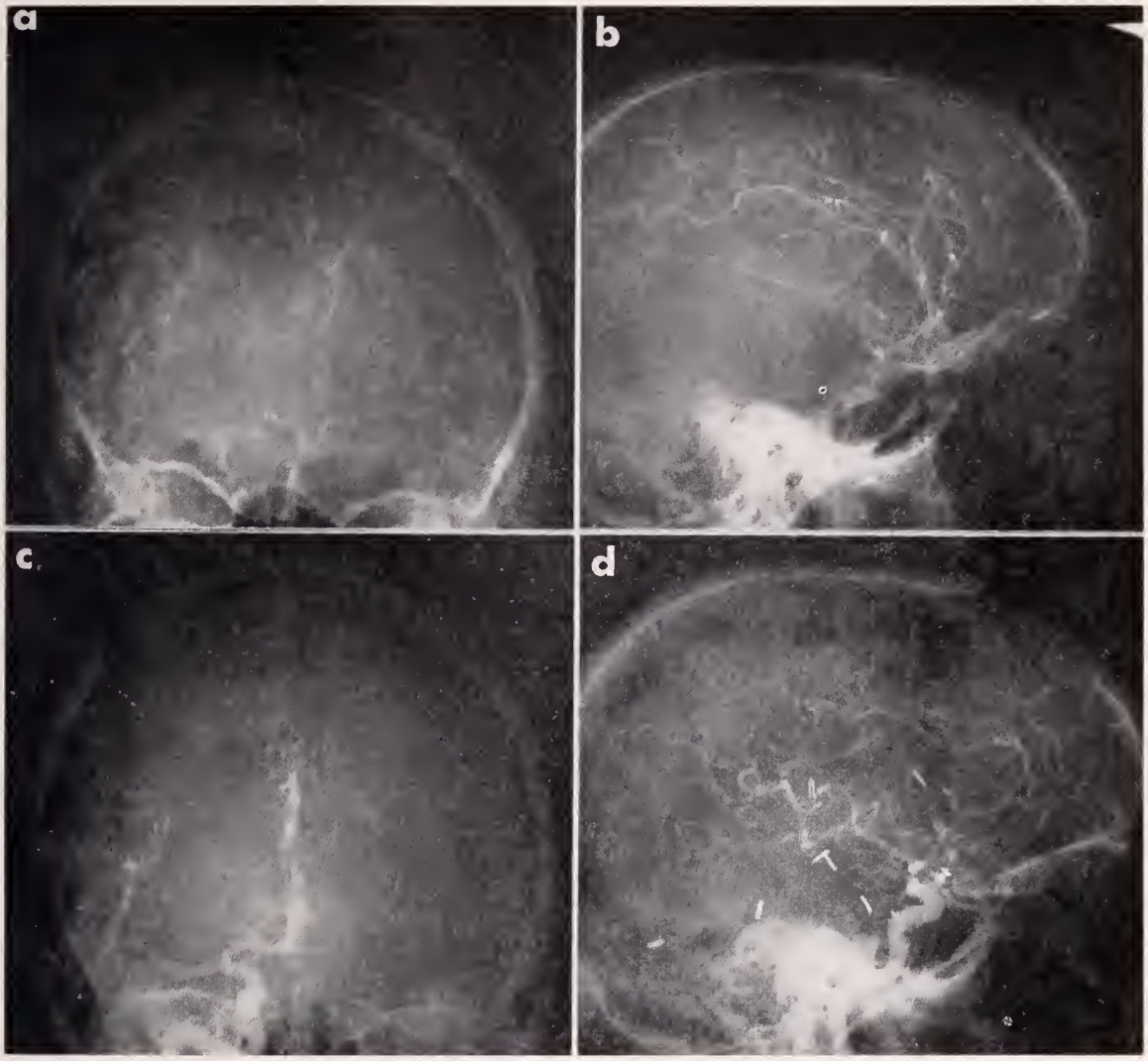

Fig. 2 (Case 2)—(a, b) Preoperative right carotid angiogram, arterial phase, demonstrating the leftward shift of the anterior cerebral artery and the marked elevation and arching of the middle cerebral artery over a large, apparently avascular mass in the right temporal lobe. The capillary and venous phases are omitted, to save space, and because of difficulty in their reproduction. (c, d) Postoperative right carotid angiogram, arterial phase, demonstrating complete return of the previously displaced arteries to their normal position after removal of the mass.

barbital and 100 mg diphenylhydantoin sodium (Dilantin) four times a day. Five days later the patient had four mild seizures in which he became aphasic but did not lose consciousness, and in one of which there was twitching in the right side of his mouth. He then was referred to our clinic. No neurological deficit was noted on examination. Roentgenograms of the head and chest and an electroencephalogram were within normal limits.

Serial left carotid angiography showed a moderately large arteriovenous malformation (Fig 4a) slightly above the anterior tip of the left frontal lobe of the brain. The lesion was supplied by branches of the frontopolar artery, and it drained directly into the superior sagittal sinus.

A lumbar puncture was done. The fluid was colorless and acellular, with a pressure of 150 mm of CSF, and a protein content of 43 mg/100 ml.

The location of the lesion in the dominant hemisphere, and the absence of definite evidence of its having bled, were considered in favor of conservative management. But, because of the patient's young age, his tendency to do physically strenuous work, and the relative accessibility of the lesion, surgical therapy was elected.

The lesion was completely excised on Aug. 25, 1965, through a left frontal craniotomy. A cyst containing about 10 to 15 ml of dark, greenish-brown fluid was associated with the malformation. The cyst was evacuated and left open to the subarachnoid space. A thin layer of necrotic brain tissue surrounded the lesion in some areas, and was removed in the course of the dissection. Recovery was uneventful, and a follow-up angiogram confirmed the complete excision of the lesion (Fig 4b).

Histological examination of the surgical specimen revealed a typical arteriovenous malformation (Fig 5a) with associated areas of encephalomalacia, gliosis, and evidence of old hemorrhage (Fig 5b).

The patient returned to work three months postoperatively, and he has had no recurrence of symptoms. His last neurological examination and electroencephalogram, in August 1967, were normal. A follow-up communication in July 1968 reported that he was asymtomatic, enjoying his work, and taking no medication.

Comment

In Case 1, the usual signs of cerebral angiomatous malformations[3, 4, 5, 6] were absent. There were no headaches, seizures, bruit or subarachnoid hemorrhage. The sudden onset of hemiplegia suggested a major cerebral arterial occlusion. While no such occlusion was demonstrated on the angiogram, the likelihood of a localized thrombosis associated with the angiomatous malformation and affecting the blood supply to the right internal capsule, should still be considered. Indeed, such a thrombosis may well have prevented the malformation from being visualized on the angiogram. Partial or complete thrombosis of angiomatous malformations has been cited by Kamrin and Buchsbaum[1] as a possible cause for their failure to opacify angiographically in some instances.

Another possible cause for the absence of angiographic opacification in Case 1 is that the malformation may have been of the cavernous type. A cavernous agiomatous malformation may fail to opacify because of its relative anatomical separation from the main stream of blood supply to the brain.[1] Jain[7] reported a somewhat similar case in which a cavernous hemangioma presented as an intraventricular tumor, well outlined in the air study but not opacified on the angiogram.

The cause of the left parkinsonian tremor in Case 1 was not known at the time of his admission to the hospital. Such tremors are not generally included among the manifestations of cerebral angiomatous malformations. However, the gradual disappearance of the tremor following surgical clipping of the nutrient vessel to this patient's lesion suggests that the tremor was probably due to shunting of blood away from the right basal ganglia while the lesion was still patent, and that its disappearance was due to gradual recovery of the previously ischemic tissue rather than to the creation of an infarct on surgical clipping.

In Case 2, the angiographic findings and the rapid deterioration at age 20 suggested a right temporal lobe abscess, but there was no history of prior recent febrile illness and no clinical or radiographic evidence of middle ear or mastoid disease. The somewhat prominent right cranial vascular markings on the skull films suggested an underlying meningioma or vascular anomaly, either of which could produce rapid deterioration with bleeding; but no tumor staining or vascular malformation of any kind could be seen in the arterial, capillary, or venous phases of the angiogram, and the mass was angiographically avasular. A highly malignant or metastatic tumor may give a similar clinical picture, but this is unlikely at age 20.

As in Case 1, the angiomatous malformation of Case 2 was not recognized preoperatively even on serial angiography. The failure of the lesion to opacify angiographically in Case 2 was probably due to compression of some of its vessels by hemorrhage and occlusion of others by secondary thrombosis (Fig 3). In Krayenbuhl and Siebenmann's[2] experience, 15 of 24 cases of primary intracerebral hemorrhage were associated with proven angiomatous malformations, but in only 10 of these was the angiomatous nature of the lesion seen on the angiogram. The failure of angiographic opacification in the rest was attributed mostly to hemorrhage and secondary thrombosis. The authors also presented evidence that an angiographically demonstrable malformation may be subsequently "extinguished" by the hemorrhage.

In Case 3, the history of recurrent headache and focal seizures was one commonly associated with cerebral angiomatous malformations. Although there was no history of subarachnoid hemorrhage proven by spinal puncture, the hemorrhagic cyst encountered at surgery and the histological evidence of hemosiderin phagocytosis (Fig 5b) suggest that the early episodes of headache and seizures may well have been associated with intracerebral bleeding. As indicated by Arseni, *et al.*[8] such bleeding may occur in different ways. It may be sudden or insidious in onset, diffuse or localized in pattern.

The misleading manifestations of the lesion in Case 3 were related to its clinical localization. The episodes of asphasia and twitching of the right corner of the mouth pointed to the left opercular or frontotemporal region while the actual anatomical location of the lesion was above the anterior pole of the left frontal lobe, 5 to 7 cm away from the clinically suspected focus. To explain this discrepancy, one may postulate that association fibers between the anterior and posterior frontal regions allowed a focus in the former region to manifest itself in the latter. A more plausible explanation, however, is that the rapid shunt of arterial blood into the malformation at times may have resulted in a relative ischemia of neighboring and distant regions. The shunt mechanism has been implicated repeatedly in the production of signs and symptoms of cerebral angiomatous malformations.[9, 10]

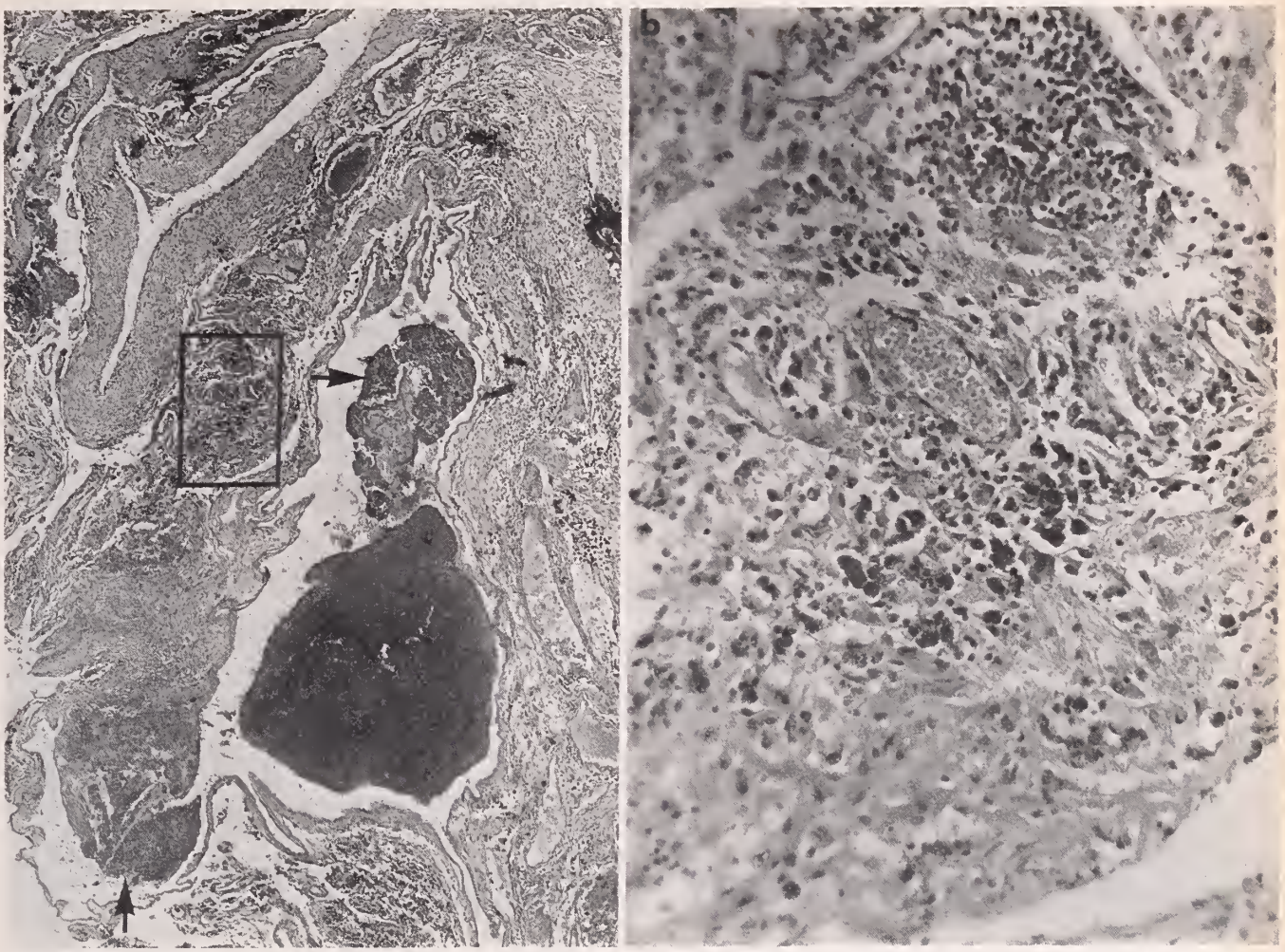

Fig. 3 (Case 2)—(a) Histological section of surgical specimen, showing a collection of arteries and veins of various shapes and sizes, with venous thrombosis (horizontal arrow) and recent interstitial hemorrhage (vertical arrow). [H. & E., X 40] (b) Detail from enclosed area in (a): Clusters of lymphocytes and hemosiderin-laden phagocytes are seen, indicating previous hemorrhage. [H. & E., X 240]

Accordingly, the purpose of surgical excision of cerebral angiomatous malformations is not solely to prevent hemorrhage but also to improve the neurological deficit when possible by eradicating the shunt and allowing the arterial blood to be diverted back to the previously deprived capillary beds.

However, surgical excision is not always possible, and indeed surgery is not always the treatment of choice.[5, 6, 9] Mature judgment is needed in these decisions, with careful consideration of the anatomical location and extent of the lesion, its feeding and draining vessels, the severity and/or intractability of the clinical problem and the patient's age and occupation. When surgery is indicated but excision is too dangerous, good results may be achieved by clipping of the nutrient vessels (Case 1), or by Luessenhop's[11] technique of artificial embolization of the nutrient vessels. However, such halfway measures, may fail, as the smaller and less visible vessels may enlarge and cause recurrence of the lesion after its major nutrient vessels have been occluded. Fortunately, this did not occur in the patient in Case 1, and complete excision was accomplished in the patients in Cases 2 and 3.

Valuable strides have been made in the surgical management of cerebral angiomatous malformations.[9, 10] An interesting technique described by Garretson *et al*[12] is claimed to facilitate the identification of nutrient vessels during surgery by coloring them with Coomassie Blue Dye injected into the internal carotid artery. With the various effective means now available for the management of these lesions, it has become increasingly important to establish the correct diagnosis, and to be ready for their encounter when the diagnosis is obscure.

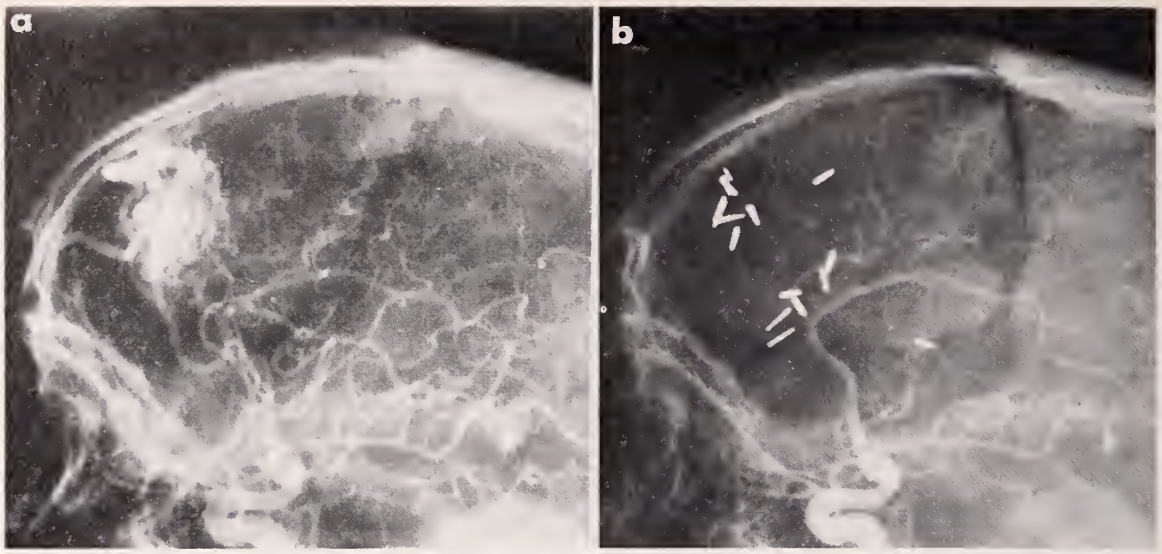

Fig. 4 (Case 3)—Preoperative (a) and postoperative (b) left carotid angiograms, lateral views of arterial phase, demonstrating the arteriovenous malformation and its total excision. Other views and phases are omitted to save space.

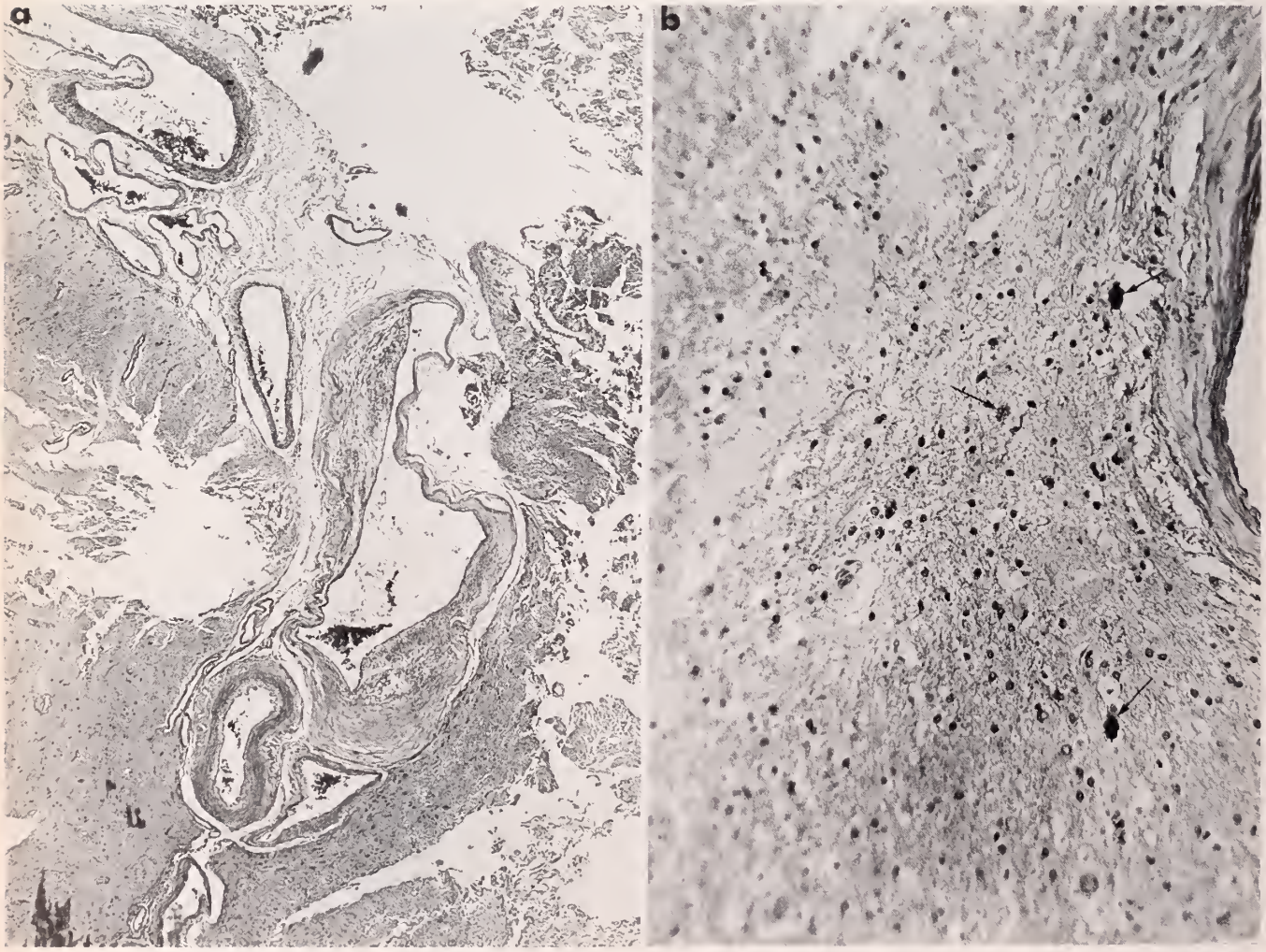

Fig. 5 (Case 3)—(a) Histological section of the excised arteriovenous malformation, demonstrating large arteries and veins in leptomeningeal tissue. [Masson stain, X 45] (b) Deeper portion of same specimen, showing encephalomalacia and gliosis adjacent to a venous wall. A few hemosiderin-laden phagocytes (arrows) also are noted, indicating previous hemorrhage. [Masson stain, X 240]

Summary and Conclusions

The classical signs of cerebral angiomatous malformations, including headaches, seizures, subarachnoid hemorrhage, and progressive neurological deficit, are not always present. They may indeed be replaced by other clinical manifestations which are not usually associated with such lesions, and the lesion may even fail to be visualized on serial angiography. Also, false localization of signs and symptoms may occur.

Three unusual cases are presented. The first patient had a long-standing parkinsonian tremor on the left side, a sudden left-sided hemiplegia, and radiographic evidence of an intraventricular mass. The mass proved to be an angiomatous malformation, and was treated by clipping of its nutrient vessel. The patient recovered from the hemiplegia and from the parkinsonian tremor, and he has been well for over nine years. The second patient had rapidly progressive headaches, personality change, and left-sided hemiplegia, with an angiographically avascular right-sided intracerebral mass. The mass consisted of old and recent hemorrhage arising from an angiomatous malformation. Total surgical removal was followed by a complete recovery which has lasted over eight years. No vascular anomaly had been seen in the serial preoperative angiograms of either of the first two patients. The third patient had an angiographically demonstrable arteriovenous malformation slightly above the left frontal pole of the brain, while the clinical focus pointed to the left frontotemporal region. The lesion was totally excised three years ago, and the patient has been asymptomatic ever since.

The mechanisms producing unusual clinical manifestations, failure of angiographic opacification, and false clinical localization are briefly discussed. With effective methods of treatment now available, a plea is made to include angiomatous malformations in the differential diagnosis of almost any severely disabling neurological disorder of cerebral origin. □

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CIRCULATORY CONTROL IN IDIOPATHIC ORTHOSTATIC HYPOTENSION (SHY-DRAGER SYNDROME)

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Of three patients with Shy–Drager syndrome, two presented with syncope related to exercise. Autonomic regulatory function was absent in two patients but heart-rate response was present in one. Hemodynamic studies were done with subjects supine and tilted 45° before and after exercise, following plasma volume expansion, and during the effects of isoproterenol and atropine. Despite disordered venoconstriction, decrease in central blood volume and right atrial pressure was not excessive with tilt, and total systemic vascular resistance remained unchanged. Cardiac index decreased (–24%). Absence of sympathetic cardiac effects may play a role in orthostatic hypotension by limiting heart rate and preventing shift of the Starling curve to the left. Amelioration of postural effects by plasma volume expansion was noted, along with increased stroke volume, indicating that heterometric regulation was operative. Atropine had little effect. Isoproterenol caused marked hypotension. Similarly, exercise, by decreasing systemic vascular resistance, produced hypotension even in recumbency. Exercise has a deleterious effect and is of value in the evaluation of patients with syncope secondary to automatic dysfunction.

Disulfiram-like Reaction to Chlorpropamide (Diabinese)

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■ THE PURPOSE OF THIS report is to re-direct attention to the disulfiram (Antabuse)-like reaction to chlorpropamide (Diabinese) which, despite its mention in standard reference works,[1] may be overlooked unless the physician carefully questions his patient. The importance of this close interrogation has been emphasized by Fitzgerald and associates,[2] and was exemplified in one of our two cases. In this same case there was also a progressive rise in blood pressure, whose possible association with chlorpropamide therapy will be discussed.

Case Reports

Case 1. A 45-year-old white man was admitted to the hospital in February 1964 for investigation of a pulmonary lesion. After right thoracotomy, segmental resection, and histologic examination, the lesion was found to be blastomycosis. The mycotic lesion was successfuly treated with amphotericin B, but it was then discovered that the patient was diabetic. During the next two years, the diabetes was controlled by dietary measures alone, but in March 1966 following a bout of gastroenteritis, it became necessary to add chlorpropamide to the regimen.

In September 1966 the patient called attention to the fact that all through the summer he had been having peculiar attacks of flushing, sweating, and palpatation when he took as little as one glass of beer. He was then changed to tolbutamide (Orinase) therapy and the reactions ceased to occur, but it was necessary to readmit him to the hospital because the hyperglycemia was no longer controlled. His past and family histories were noncontributory. He was an alert, intelligent, cooperative, muscular individual, well developed for his age.

The only pertinent findings were a fasting blood sugar of 314 mg/100 ml, with a small amount of sugar and protein in the urine. The course of eight days in the hospital was uneventful except for two minor insulin reactions; he was discharged on an 1800-calorie diet and 15 units of isophane insulin suspension (NPH Iletin) and no oral antidiabetic compounds. There have been no flushing episodes subsequently.

Case 2. A 42-year-old white man, whose diabetes had been diagnosed at the age of 24, had been placed on protamine zinc insulin after initial failure with dietary measures alone. Many trials of the oral hypoglycemic compounds had been made subsequently, without much success. During one of these, in the early summer of 1966, when taking 750 mg of chlorpropamide daily, the patient began to experience flushing and headache within 15 minutes of taking his habitual brandy and seltzer before dinner in the evening. The headache lasted four to five hours, after which all symptoms disappeared. No episodes occurred in the absence of alcohol ingestion. The patient had made no mention of these reactions until five months after their first occurrence, when he was carefully questioned about alleged episodes of left extremity weakness, which were not substantiated by the examiner. The occurrence of flushing, together with a progressive rise in blood pressure and elevated urinary vanillylmandelic acid (VMA) values, raised the suspicion of a pheochromocytoma and led to hospitalization.

Before the chlorpropamide trial, a blood pressure of 138/88 mm Hg had been recorded, but the pressure elevated steadily during use of the drug and at the time of admission was 170/110 mm Hg in the right arm and 160/90 mm Hg in the left arm. Two 24-hour urinary VMA values prior to admission were 13.5 and 16.6 mg. Values obtained subsequently in the hospital on a controlled diet were 9.5 and 11.7 mg. A phentolamine (Regitine) test was within normal limits. The only positive neurologic finding was an absent left ankle jerk.

When the patient was changed from chlorpropamide to insulin therapy he promptly tried his reaction to alcohol, and experienced no disturbance. His blood pressure at time of discharge had returned to 138/90 mm Hg; on May 12, 1967, it was 138/84 mm Hg; on July 14, 1967, 132/86 mm Hg; on Sept. 29, 1967, 136/84 mm Hg. On Sept. 18, 1967, the 24-hour urinary VMA value was 1.6 mg, and on Oct. 3, 1967, 2.7 mg, both within the normal range.

Discussion

Circulatory reactions of the disulfiram type, in patients ingesting alcohol while under the influence of oral antidiabetic compounds, were recorded almost coincidentally with the introduction of these drugs in 1955. The first report in a widely distributed journal, that of A. Czyzyk and G. Mohnike[3] in Karlsburg in 1957, dealt largely with animal experimentation but also recounted a few clinical reactions. In the same year, Henry Dolger,[4] at the Mount Sinai Hospital in New York, reported five instances of marked face and body flushing after alcohol ingestion in 500 patients taking tolbutamide. There then followed reports of a similar nature from Chile, Argentina, Australia, Mexico, England, France, Austria, and Italy.

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In England, M. G. FitzGerald's group[2] observed that 22 of their 65 patients who had consumed alcohol while taking chlorpropamide experienced at least mild symptoms of the disulfiram-reaction type, and they concluded that this was a common complication of chlorpropamide therapy. They noted also that it occurred with equal frequency in drinkers of beer or spirits and emphasized the fact that many patients, feeling that they had transgressed in taking alcohol, did not mention the reaction spontaneously. In France, R. Royer and associates[5] observed the reaction in some instances in nondiabetic patients who volunteered to take the oral sulfonylureas, and went so far as to propose the substitution of chlorpropamide for disulfiram in treating alcoholics.

Thus it has been amply shown that some individuals who ingest alcohol while taking sulfonylurea antidiabetic compounds, particularly chlorpropamide, experience a reaction resembling the one well known to occur in the alcoholic individual who imbibes while taking disulfiram. The occurrences underlying these reactions are not fully understood.

When alcohol is taken under ordinary circumstances, it is oxidized by alcohol dehydrogenase in the liver, and then the acetaldehyde produced in this reaction is quickly oxidized further by aldehyde dehydrogenase. However, when there is a sufficient disulfiram titer in the blood, this second oxidation is considered to be prevented. The patient then experiences the disulfiram reaction: generalized vasodilatation, hypotension, palpatation, blurring of vision, headache, and sometimes copious vomiting.

The first observers to attribute medical significance to this reaction (which had long been crudely known in certain of the industries), the Danish investigators Hald and Jacobsen,[6] considered the increased blood acetaldehyde titer to be solely responsible for the reaction, and this has been the generally accepted view.

Actually, the observation of Truitt's group,[7] at the University of Maryland, that in the experimental animal both tolbutamide and chlorpropamide induce rises in blood acetaldehyde when alcohol is administered, appears to explain the sulfonylurea reaction upon the same acetaldehyde-increase basis. However, other workers, notably Lester and Greenberg,[8] have pointed out that when large amounts of alcohol are taken alone, blood acetaldehyde levels exceeding those induced by disulfiram may occur without engendering the disulfiram type of reaction. So one can only conclude that the matter is still in the controversial stage.

FitzGerald's group[2] feel that both reactions, that to disulfiram and that to sulfonylurea, possibly share a common cause, which can be interpreted as a nonspecific exaggeration of the normal response of small blood vessels to ethyl alcohol. It is noteworthy, however, that the intravenous injection of acetaldehyde in the experimental animal causes a *rise* in blood pressure whereas in man the predominant symptom is hypotension.

The rise in blood pressure noted in our second patient may be related in some manner to the observations in the experimental animal. Urinary VMA was elevated on three occasions during chlorpropamide therapy in this case and fell to normal levels after discontinuance of the drug. Since the determination of VMA was changed in the laboratory from the Hy Cell Kit to the more specific method of Pisano[9] in July, 1967, the values obtained in early 1967 are not strictly comparable with the later ones. Nevertheless, the wide disparity between the mean value of the four Hy Cell Kit determinations (12.3 mg/24 hours) and the two Pisano determinations (1.0 mg/24 hours) may suggest that a significant change in urinary VMA excretion did occur and was related to the rise and fall in blood pressure. In the review of Sjoerdsma and associates[10] there was no mention of artificial elevation of urinary VMA by the excretion of chlorpropamide.

Summary

Two cases of a disulfiram-like reaction after alcohol ingestion by chlorpropamide-treated diabetic patients are reported, and the incidence and nature of this reaction are discussed. A progressive rise in blood pressure, associated with elevation in urinary vanillymandelic acid (VMA), was noted in one patient. The disulfiram-like reactions ceased to occur in both individuals when chlorpropamide (Diabinese) was discontinued, and the blood pressure and urinary VMA rises also disappeared in the one who had exhibited these abnormalities.

Addendum

Since submission of this article, Podgainy and Bressler (*Diabetes* 17:679–683, 1968) have demonstrated noncompetitive inhibition of aldehyde dehydrogenase by sulfonylureas and feel that this coupled with the actions of ethanol may be considered a potential cause of the sulfonylurea-induced disulfiram (Antabuse) syndrome. □

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PEUTZ–JEGHERS SYNDROME WITH METASTASES TO AN ABDOMINAL INCISION

SANFORD MACKMAN, MD; GIUSSEPPE PERNA, MD; and FRANK GOSSETT, MD, Madison, Wis: **Archives of Surgery** 98:99–102 (Jan) 1969

Peutz–Jeghers syndrome is a well recognized clinical entity. The polyps, which are generally in the small intestine but may be found throughout the gastrointestinal tract, are peculiar in that they contain all types of epithelial cells found in the gut arranged in the usual manner on a branching stoma and are thus felt to represent hamartomas. Because of this unusual histological appearance, they often have been misinterpreted as invading muscularis and are thus considered by some as being malignant. In reality, only 6 of the more than 300 cases reported, have the polyps shown definite malignancy with matastasis. This article reports a case of Peutz–Jeghers syndrome with definite metastases to the abdominal incision from a polyp removed five years ago.

USE OF SPANDEX AS A VASCULAR PATCH GRAFT MATERIAL

MARVIN WAGNER, MD; GEORGE REUL, JR. MD; JOSEPH TERESI, MD; and KENNETH KAYSER, MD, Milwaukee, Wis: **Surgery, Gynecology and Obstetrics** 127:805–807 (Oct) 1968

In the past several years, the textile industry has employed a synthetic spandex fiber which has been used commercially in "stretch" cloth. The spandex material used in this study was Lycra.® The number 70 denier fiber was fabricated into a knitted vascular patch graft for pilot studies. A total of 42 patch grafts were applied to canine abdominal aortas. Defects were created in the abdominal aorta and were so made that one-half of the circumference of the host vessel was excised and the length varied from 1 to 2½ centimeters. The defect was patched with the spandex graft. Postoperatively, the dogs were placed on a breeding farm until the time of restudy. The dogs were sacrificed between 6 weeks and 22 months after application. This chronologic distribution of implant age was suitable for the histologic assessment of the healing pattern. One-half of the group of dogs had periodic aortograms to note the integrity of the graft. The specimens from the five oldest were used for tensometer studies comparing the patch graft with the host aorta.

RESULTS: Results showed that all host vessels remained patent. Four deaths occurred in the series. One, dehiscence of wound; another dog died from hemorrhage; one dog died 12 days postoperatively with retroperitoneal hematoma, and the fourth dog died on the second postoperative day, thrombosis of the abdominal aorta. The specimens were examined grossly and histologic sections were made. Study of all the aortograms showed neither evidence of aneurysmal dilatation nor stenosis at the site of the patch. Several dogs were studied at periodic intervals, whereby increased pulsatile and sustained intraluminal pressures were performed. In all the dogs studied, the patch graft maintained its integrity. Tensile strength determinations were performed on the implanted spandex patch grafts of five dogs which were in situ from 21 to 22 months, using the Instron® apparatus. The tensile strength of the implanted graft was compared with a segment of the respective host aorta. The results of these tests indicated that Lycra® patch grafts are similar to the aorta.

SUMMARY: Spandex material, an inherent synthetic elastic fiber, was used as an arterial patch graft in the abdominal aorta of 42 dogs. The results, including the histologic findings, indicate that spandex material has a place in the armamentarium in the field of vascular surgery.

Therapeutic Dilemmas

No. 16 of a Series

Editor:

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These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

EXTRAPYRAMIDAL PHENOTHIAZINE REACTIONS

Moderator: JOHN F. BECKER, M.D.

Participants: SAMUEL E. HOKE, M.D.
DOUGLAS D. KLINK, M.D.
NICHOLAS L. OWEN, M.D.
MARIO DE OLIVEIRA, M.D.
WILLIAM C. JANSSEN, M.D.

Dr. John F. Becker: The two cases will be described rather sketchily this morning because our prime interest at this time lies not in the maladies themselves but in the reactions to a drug that was given to each of the patients. Doctor Hoke will present the cases.

Dr. Samuel E. Hoke (Resident in Medicine): The first patient, a 37-year-old white woman, was seen for the first time in this hospital in the emergency room. She was up and about, but complained of inability to chew, of a tongue that protruded and was difficult to move, and of some difficulty in speech. At this time the speech was found to be slurred and the tongue appeared hypertonic and apparently a little impeded in motion. There was no nystagmus, and the results of the physical examination were otherwise essentially normal. The history was of the use of a 25-mg prochlorperazine (Compazine) rectal suppository at 48 hours, and again at 24 hours, before coming to the hospital. She was given 50 mg of diphenhydramine (Benadryl) intramuscularly and 2 mg of trihexyphenidyl (Artane) orally, and admitted. The symptoms rapidly cleared and she was discharged asymptomatic, as far as this episode was concerned, after 18 hours.

The second patient, a 29-year-old white woman, was also seen for the first time in this hospital, so far as our present interest is concerned, in the emergency room. The chief initial complaint was of vertigo, nausea, shaking, and muscle spasms. She was alert and oriented, but at intervals there were episodes of opisthotonos and oculogyric crisis. There was a history of having taken 10 mg of prochlorperazine (Compazine) orally three times daily for the preceding 3 days. She was admitted and treated with diphenhydramine (Benadryl) and benztropine (Cogentin) and discharged after 2 days.

Dr. Becker: Here then we have two instances of a type of reaction, in different degrees of severity, to a psychotropic drug of the phenothiazine group. Doctor Klink, the first patient had been under your care before she came to the hospital. Have you anything to add with respect to the drug reaction?

Dr. Douglas D. Klink: This is the second of these distressing reactions that I have seen in the last month and a half, in both instances in association with the use of 25-mg prochlorperazine (Compazine) suppositories. Two other physicians have told me of similar experiences. In one of these cases it was not immediately apparent that the opisthotonos episodes during the night were not directly associated with a severe viral infection from which the patient had been suffering; in fact it was only the prompt response to diphenhydramine (Benadryl) in the early morning hours that made the diagnosis. In each case, phochlorperazine had been given as the 25-mg suppository.

Dr. Becker: Doctor Owen, yours was the more stormy of our two cases. Would you care to comment?

Dr. Nicholas L. Owen: I had never met this young lady until I saw her in the emergency room that night, but as a victim of Meniere's syndrome she is probably known to all the younger surgeons who staff the emergency room here because she presents frequently with a burn or laceration or something of that sort as a result of one of her falls. She has suffered from this syndrome of vertigo, tinnitus, and falling for many years and has had numerous doctors during the past decade. There have been a number of operations, the most significant of which was for removal of a papillary carcinoma of the thyroid, that has not metastasized to the present time. When I saw her in the very frightening attacks of opisthotonos and oculogyric crisis, which I was unable to relieve quickly with diphenhydramine (Benadryl), I became quite uncomfortable and called Doctor de Oliveira for consultation. She then responded promptly to more vigorous antidotal therapy.

A Physician: Were the antidotal drugs given intramuscularly or intravenously?

Dr. Hoke: Intramuscularly in both cases.

A Physician: How did you distinguish these crises from hysteria?

Dr. Owen: This was not easy to do and was why I called for specialist help. She would lie quietly in bed for 4 or 5 minutes and then, when she was stimulated by testing or merely by talking to her, she would roll up her eyes and her head would go back almost as though she were having a convulsion. Such a seizure would last for a couple of minutes. I felt that these were not truly convulsive affairs because the area of involvement was not consistent; at one time it would be on one side and at another time on the other side. And they were not as complete as you would expect in a Jacksonian episode. But I was not so sure regarding hysteria. I was helped somewhat, however, by the patient's statement that she had been made "sick" by others of the phenothiazines in her long therapeutic career. She did not believe that she had ever received prochlorperazine (Compazine) before.

Dr. Becker: As we all know, these synthetic phenothiazines are used not only to allay the symptoms of Meniere's disease, as in this case of Doctor Owen's, but in treatment of the major psychoses and minor anxiety and tension states, as anti-emetics, as potentiators of analgesics and anesthetics, in petit mal epilepsy, in hiccup, and to alleviate the pain and nervousness of porphyria. They also have a broad spectrum of toxic reactions: blood dyscrasias such as agranulocytosis and hypoplastic anemia, a cholestatic type of jaundice, numerous evidences of their anticholinergic (atropine-like) action, photosensitivity, melanin-like granular pigmentation in all parts of the eye except the vitreous, breast engorgement, weight gain, menstrual disturbances, and—the matter of our chief concern today—the reactions indicative of action high up in the central nervous system. It is these extrapyramidal reactions that Doctor de Oliveira will now discuss from the standpoint of his knowledge and experience as a neurologist.

Dr. Mario de Oliveira: In the beginning of our experience with these drugs the notion got about that these extrapyramidal reactions were always benign affairs and that indeed full therapeutic effect could not be achieved unless the patient experienced some degree of such reactions. We now know that neither of these things is true. In fact, while the reactions are nearly always reversible, they may occasionally be irreversible to the point that not even surgical procedures are alleviating. And the full effects desired in any of the maladies in which the drugs are used can certainly be achieved without the occurrence of extrapyramidal reactions. There is not even satisfactory evidence that the reactions are distinctly dose-related, despite the impression to this effect that has been fostered in some of the sales promotion.

When we consider the fact that many, many millions of doses of these drugs have been administered to many millions of patients, it is of course impossible to say that we know with any exactitude what the incidence of the extrapyramidal reactions is, but there is available one careful study, that of Ayd, in Baltimore in 1961 (F. J. Ayd, *J.A.M.A.* 175:1054, 1961), who found an overall incidence of such reactions in 38.9% of 3,775 patients treated for major psychoses with the potent members of this drug group.

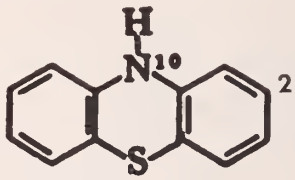

Fig. 1—Phenothiazine

I think it would be of some value to us at this point to say something about the two groups into which these drugs can be separated chemically, because some therapeutic distinctions can be based upon this. The phenothiazine nucleus (Fig 1) can be substituted at points 10 and 2 of its structure. Of the principal compounds in use in neuropsychiatry today, three—promazine (Sparine), chlorpromazine (Thorazine), and triflupromazine (Vesprin)—result from introduction of straight chain, aliphatic radicals at the 10 position. The others—acetophenazine (Tindal), carphenazine (Proketazine), fluphenazine (Permitil, Prolixin), perphenazine (Trilafon), trifluoperazine (Stelazine), thiopropazate (Dartal), and the agent we are concerned with today, prochlorperazine (Compazine)—are the result of the substitution of a more complex piperidine radical at position 10. The important aspect of this for clinical practice is that, in the main, the aliphatic compounds are more prone to cause parkinsonian-type reactions, and the piperidines more prone to produce dyskinetic-type reactions as described in our two patients today. One other compound, thioridazine (Mellaril) differs chemically from both these groups in having a different type of radical substituted at the 10 position, and it is less likely than any of them to cause extrapyramidal reactions.

Now since I have spoken of parkinsonian-like and dyskinetic-type of reactions, let me amplify this and add a third type, akathisia. This last

reaction is one of muscular restlessness. The patient is unable to sit or lie still, in fact has constant need to pace the floor. There is continuous flexion and extension of the feet and often dystonic movements of the face. This is a terribly incapacitating thing, but I do not see it often in my practice. In Ayd's series the incidence was about 21%, but his were predominantly patients in the upper age range. The well-known parkinsonian symptoms mimic pretty closely those of genuine Parkinson's disease or paralysis agitans: mask-like facies, poverty of associated movements, fixed posture, rigidity, and in time even the tremor at rest if the use of the drug is prolonged and the dosage high and the individual susceptible. Tremor is said to be the initial symptom in the majority of true Parkinson patients, whereas in phenothiazine reactions it is usually rigidity and poverty of associated movements that are first seen.

The third type of reaction, the one with which we are concerned today, the dyskinetic, is expressed principally in these cases as dystonic movements. Posturing of the head, neck, and tongue are typical and bizarre manifestations that often, as in our second case, are difficult to distinguish from hysteria. The tongue movements are often of the fly-catcher type—rapid protrusions and withdrawals—of the sort that physicians of an earlier day used to see in von Economo's encephalitis. Then there are also retrocollis and torticollis and the typical oculogyric crisis, which is an abnormal upward rolling of the eyes with accompanying retrocollis. And there are dystonic movements of the trunk and limbs and often opisthotonos also. All these movements can be voluntarily inhibited for a certain period, but as the patient attempts to limit the movement in one area there is an exaggeration of movement in some other area. This ability to bring about a temporary cessation of movement is a point of some differential importance, because in Huntington's chorea if you ask the patient to maintain a fixed posture the result is simply an aggravation of his choreatic movements.

In Ayd's series, the incidence of dystonic movements was only 2.3%, but it is higher among those of us who see younger patients. It is our experience that patient susceptibility rather than dosage or duration of therapy is the important factor in the dystonic reaction, whereas in the parkinsonian reaction the reverse seems to be the case. Roughly, one could say: expect the dystonic reaction in young persons, akathisia in the middle-aged, and parkinsonism in the older individuals.

One should mention also the tendency of these drugs to aggravate a seizure disorder and perhaps even provoke convulsions de novo. And there are also typical electroencephalographic changes, mostly of a dysrhythmic nature; if the alterations are in the nature of delta activity, you should probably think in terms of another diagnosis.

The mechanism of the dyskinetic reactions is unknown. We believe that a release of the function of the pallidum, which is normally inhibited through the substantia nigra, putamen and subthalamic nucleus of Luysi, could cause all these abnormal movements, but Roizin's group (L. Roizin et al, *Ass. Rev. nerv. ment. Dis.* 37: 285, 1959) have been unable to draw conclusive findings from their extensive studies in animals. The fact that we can reverse the symptoms so rapidly with antidotal drugs, at least in the early stages, makes it difficult to postulate an anatomical alteration in the basal ganglia; but undeniably there are cases that are irreversible, even with surgical measures. So we just don't know.

Then I would add sudden death to the list of phenothiazine reactions that Doctor Becker provided earlier. Hollister and Kosek (L. E. Hollister and J. C. Kosek, *J.A.M.A.* 192:1035, June 21, 1965), in California, attributed sudden death in 6 young individuals to these drugs, postulating ventricular fibrillation as the mechanism. We know that the patient on phenothiazines has some electrocardiographic alterations, principally ST and T wave changes. Other observers have postulated strong vagal influence causing sino-atrial arrest.

The differential diagnosis in the dyskinetic cases can certainly be difficult. The first few cases I saw I thought were hysteria because of the fly-catcher tongue, but in doing this I made two mistakes. The first mistake was to base a psychiatric diagnosis on a neurological finding, which would be comparable to a psychiatrist making a neurological diagnosis by checking the patient's mental status. In both instances, one would be using the wrong tool. My second mistake was to disregard the extreme anxiety of these patients, because the patient with a conversion reaction is comfortable. He may have a para- or even a quadriplegia, but he is comfortable because this thing is protecting him against anxiety.

Another subject for consideration would of course be chorea, but these are not the choreatic movements we see in young people; furthermore, in Huntington's chorea we have the exacerbation through fixed posture, of which I have already spoken, and there is the mental deterioration if the patient is along in years and in addition the family history, for Huntington's is an autosomal dominant process.

Hepatolenticular degeneration (Wilson's disease) also must be considered. Here you can have disordered movements from tremor to parkinsonism, but not, I believe, the dystonic type nor oculogyric crises; and the patient has typical wing-beating movements of the arms that are not seen in phenothiazine intoxication. Furthermore there is the Kayser–Fleisher ring, and if, in addition, you find a normal serum uric acid you can feel confident of having screened out Wilson's disease, for the uric acid is very low in it. Tetanus can offer difficulties, but there is usually prodromal headache, and tiredness, and one thing that has always impressed me in tetanus is the patient's profuse perspiration. And there are also the heightened reflexes and convulsions in tetanus. Of course the response to an antiparkinsonian drug will often reassure you in the diagnosis.

In the matter of treatment, the usual recommendation is that administration of the phenothiazine be stopped at once and antiparkinsonian drugs be given. I would certainly agree with this if the reaction is of the akathisia or dystonic types and the drug is being used for one of its minor indications, such as to combat nausea and vomiting, in a younger person; but I do not think it should be discontinued if the reaction is parkinsonian in an individual who is requiring relatively high dosage to control a major psychosis.

As for choice of antidotal agent, I can only say that my success has been better with an antihistamine than with an antiparkinsonian. Allegedly the antiparkinsonians, such as biperiden (Akineton) or benztropin (Cogentin), take effect in the dystonic cases in about 10 minutes when given intramuscularly and reach maximum effect in 30 minutes, and they may be repeated in half an hour, following this with oral medication. But in my experience, 50 to 100 mg of diphenhydramine (Benadryl) intravenously has been much more effective. I have had very poor results with barbiturates. Some people have used diphenylhydantoin (Dilantin), but it has no value in this situation.

A Physician: Is it safe to let the patient go home after you have controlled the extrapyramidal reactions with your drugs?

Dr. de Oliveira: I think so. It is very unusual not to have the situation in hand within 24 hours in an individual with the dystonic movements. Doctor Owen's patient was among the most violently affected that I have seen—severe opisthotonos and oculogyric crises; and even though she did not respond to therapy in the usual immediate fashion, she was nevertheless fully under control within 24 hours.

A Physician: Conceivably a patient, about whom you know nothing, could come into your office or into the emergency room at the hospital with these extrapyramidal symptoms. Are there any drugs other than the phenothiazines that should be considered in the causative role?

Dr. de Oliveira: The rauwolfias—Raudixin, Moderil, Serpasil, and the like—can induce this sort of thing, but they tend to produce the parkinsonian much more often than the dystonic type.

Dr. Becker: Doctor Janssen, what's the situation regarding the antidepressants?

Dr. William C. Janssen (Lakeside Laboratories): Among the antidepressant agents that are not monoamine oxidase inhibitors, amitriptyline (Elavil) and imipramine (Tofranil), though differing significantly chemically and in their clinical uses from chlorpromazine, have qualitatively quite similar actions in experimental animals; yet reactions of the sort we are considering today have not been recorded in man save in mild form and in very rare instances. The same may be said of desipramine (Pertofrane, Norpramine), which is a metabolite of imipramine. Possibly the thing that saves these tricyclic antidepressants from having phenothiazine-like side effects is that the top effective dosage is low—150 mg daily in most cases. During the clinical research on desipramine, it was found necessary to push the dosage up to between 300 and 600 mg daily to achieve a 25% incidence of side effects; and interestingly at such high dosage the therapeutic response rate was reduced.

A Physician: There are phenothiazines in use other than the psychotropic ones, such as the antiemetic pipamazine (Mornidine), the antihistaminic pyrathiazine (Pyrrolazote) and the sedative and antiemetic propiomazine (Largon). Do extrapyramidal reactions occur with these compounds?

Dr. Janssen: They have not been reported, and no one knows, I believe, just what it is in the slightly variant structures of these compounds that is protective.

A Physician: In a recent meeting that I attended the point was emphasized that many of the sedative type of drugs we use in attempting to relieve the apprehension and anxiety of the patient with Parkinson's disease may actually aggravate the malady. Even the barbiturates were indicted. Doctor de Oliveira, have you experienced such a thing with phenobarbital?

Dr. de Oliveira: I certainly feel that the barbiturates aggravate parkinsonism and should not be used. With regard to the antidepressants, I have seen slight parkinsonian-like reactions but never dystonia or akathisia.

A Physician: Are there premonitory symptoms that might warn one of an impending extrapyramidal phenothiazine reaction?

Dr. de Oliveira: We know that these drugs have a considerable anticholinergic effect in the automonic nervous system, and therefore any complaints of excessive dryness of the mouth and skin, urinary difficulties, alterations in pulse rate, visual disturbances, nasal congestion, constipation, hypotension, and things of that sort should be taken as suggestive of a considerable susceptibility of the patient to some actions of the drug and should therefore put one on guard at least. One very definite hazard in using these agents is that a certain type of individual, if he feels himself becoming jittery (which could be the beginning of akathisia), will increase his dosage on his own responsibility and of course only worsen the situation. Or you may not yourself appreciate fully what is going on and order the drug to be taken in higher dosage.

A Physician: Regarding the matter of unexplained deaths in association with use of the phenothiazines, I believe we should not be too hasty in accepting this as condemnatory of the group, although the number of reported cases has considerably increased since Hollister's report to which Doctor de Oliveira referred. Actually, Doctor Hollister himself drew attention to the fact that among 40,000 necropsies on soldiers dying during World War II, there had been sudden death in 1,000 instances and 140 of these deaths remained unexplained. This is certainly a pretty high incidence of this sort of thing totally unassociated with the use of phenothiazine derivative compounds.

Dr. Becker (summarizing): This morning we have had the presentation of two cases in which phenothiazine drugs caused reactions of an extrapyramidal nature, mild in one instance and very severe in the other. The full implications of these occurrences have been discussed as well as antidotal measures and the possible warning signs of an impending occurrence of this sort. □

ANTIARRHYTHMIC

Bretylium tosylate, a Burroughs Wellcome product all but forgotten following its unsuccessful use in hypertensives, is being hailed as the drug of choice in acute ventricular fibrillation. University of Minnesota clinicians who have observed its almost miraculous ability to control fibrillation predict its widespread clinical application with arrhythmias associated with myocardial infarction, cardiac surgery, digitalis intoxication, and hypothermia.

The antifibrillatory agent is now employed almost routinely in cardiac surgery at the Center; no patient so treated has died in ventricular fibrillation. The only significant side effect noted to date is lowering of blood pressure in an occasional patient; this rarely if ever occurs in bedfast patients.—From *International Medical Digest*, July 1968

HYPERPARATHYROIDISM AND ITS CLINICAL EFFECTS

CHARLES MARKS, MD, Mount Sinai Hospital of Cleveland (formerly at Marquette School of Medicine, Milwaukee, Wis.): *Amer J Surg* 116:40–48 (July) 1968

It is important to appreciate that diverse clinical manifestations may be attributable to hyperparathyroidism and a high index of suspicion is necessary in regarding the diagnosis and in defining the appropriate lesion at surgical exploration.

Hyperparathyroidism may occur insidiously over many years or decades without the development of major bone changes, especially in people whose bones are protected by an adequate intake of milk and milk products. In the past ten years 28 patients, with established diagnosis of primary hyperparathyroidism, have undergone surgical therapy at the Marquette University group of affiliated institutions, providing experience in the diagnostic and therapeutic aspects of this disease.

The development of renal calculi provides the most common clinical manifestations with colic, hematuria, urinary infection and renal failure. In 65% of this series, renal calculi precipitated an acute presentation of the patient for medical advice and treatment. In only one patient was nephrocalcinosis present, while persistent hypertension in four of the cases was attributable to chronic renal changes.

The high incidence of peptic ulcer disease in hyperparathyroidism is noteworthy and was present in 12 patients in this series, providing an incidence of 43%. Especially significant was the presence of stomal ulceration occurring in three patients who had previously undergone vagotomy and gastric resection. This may occur as a result of hyperparathyroidism existing per se or may be associated with the polyendocrine syndrome with associated ulcerogenic pancreatic islet cell adenoma or carcinoma as well as pituitary adenoma.

Episodes of acute pancreatitis may antedate the diagnosis of hyperparathyroidism and did so in five patients, or 18% of the series, but the mechanism of its causation is obscure.

In only four patients was the occurrence of bone changes noted. These included generalized demineral-

continued on next page

ization, pathologic fracture through an area of osteitis fibrosa cystica, as well as radiologic changes, such as subperiosteal resorption of bone or loss of dental lamina dura. Metastatic calcification has been seen in the kidneys and the choroid plexus and may also occur in the tympanic membrane with ensuing deafness or may involve the conjunctivae over the tarsal plate causing a sensation of eyelid irritation, while band keratopathy may be evident on inspection of the cornea. Calcific deposits have been noted along tendons and in the nails; while involvement of peripheral arteries may lead to claudication, trophic ulceration or gangrene of a limb.

An adenoma of the parathyroid gland or glands may occur concurrently with similar involvement in other endocrine glands, representing the polyendocrine syndrome, and four patients were diagnosed in the series who had involvement of the pituitary, pancreas or adrenal glands as well as involvement of the parathyroid glands.

Hypercalcemia due to hyperparathyroidism is known to affect the central nervous system and may lead to personality changes with psychic disorder, progressing to delirium, coma and death. In a hypercalcemic crisis, the vague symptoms of lassitude, weakness, fatigability and anorexia may progress to nausea and vomiting with the rapid development of somnolence, confusion, disorientation, stupor and coma. Although personality changes and frank psychosis may be marked, reversion to normal may occur after parathyroidectomy.

Biochemical disturbances are characteristic of primary hyperparathyroidism and include hypercalcemia, hypophosphatemia, hypercalcinuria and hyperphosphaturia. Serum tests for calcium and phosphorous should be carried out with the patient in the fasting state and the blood collected without occlusion of the veins to prevent spurious elevation of the serum calcium level. As hyperparathyroidism with repeatedly normal serum calcium levels is known to occur especially in the presence of low serum albumin levels or renal failure, the estimation of ionizable fractions of serum calcium in these borderline cases may be necessary. It is important to appreciate that high blood calcium levels may result from other causes, requiring differentiation from secondary parathyroid hyperplasia due to renal disease, hypervitaminosis D, milk-alkali syndrome, and osteoporosis due to prolonged immobilization. There may on occasion be difficulty in differentiating hypercalcemia due to primary malignant disease. The hypercalcemia of hyperparathyroidism is resistant to the lowering effects of cortisone because serum calcium elevation is mediated by the bones and kidneys, but the cortisone test will help to differentiate the hypercalcemia of Boeck's sarcoid, as the steroid blocks the activity of vitamin D in the intestinal absorption of calcium.

Although hyperphosphaturia may occur in osteomalacia due to vitamin D deficiency and gastrointestinal malabsorption and in renal tubular acidosis, it is strong presumptive evidence that in the absence of renal disease, a diminished tubular reabsorption of phosphorous [TRP] with corresponding hyperphosphaturia represents hyperparathyroidism, as a functioning parathyroid adenoma will depress the maximal tubular resorptive rate for organic phosphate.

The preoperative identification of parathyroid adenoma may be mediated by plain radiography which will demonstrate displacement of the trachea, if the adenoma is larger than 2 cm in size, and rarely may demonstrate esophageal deformation. Photoscanning techniques utilizing methionine selenium 75 as a radioactive isotope has unfortunately not been a method of accurate localization, while arteriography may demonstrate that the affected inferior thyroid artery is almost double the diameter of the normal side. It needs to be stressed, however, that these diagnostic auxiliary measures cannot be permitted to replace total operative identification of all the parathyroid glands.

Surgical treatment is necessary for cure of a hyperfunctioning parathyroid adenoma, and, in 23 cases in the present series, one adenoma was present; in three cases, two adenomas were found; and in two cases, multiple adenomas were discovered. Four patients, as mentioned earlier, represented examples of the polyendocrine syndrome. As it is desirable to identify all four parathyroid glands, a standard cervical collar incision provides adequate access for this purpose. A pathologic frozen section examination may help differentiate parathyroid from lymphoid tissue, as well as helping to differentiate in the presence of pathologic changes between hyperplasia or adenomatous change. In the presence of diffuse hyperplasia, it becomes necessary to remove three glands totally, whereas the fourth is resected subtotally and, if no lesion is found and the diagnosis of hyperparathyroid hypercalcemia is assured, thyroidectomy is performed in the hope that an intrathyroid parathyroid adenoma is present. Further procedures are deferred until metabolic studies have been repeated and the resected tissue appraised microscopically.

If calcium and phosphorus studies continue to give abnormal results and differential diagnosis of the hypercalcemic state excludes all other possible causes, transsternal mediastinotomy is performed and a further diligent search of the mediastinum is carried out.

After removal of the causative parathyroid adenoma it is not uncommon to find a sudden drop in the serum calcium level with occasional development of carpopedal spasm and other features of hypocalcemia, making it necessary to provide infusion of calcium gluconate. Within 72 hours, however, the serum calcium gradually returns to normal and generally it remains normal.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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PART II: NASAL AGENTS and OROPHARYNGEAL AGENTS

Topical Medication in Otolaryngology

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Nasal Agents

Any topical medication used to improve nasal function must protect cilia and conserve mucus.[3] Cold water vapor transmitted through humidifiers will fulfill these criteria. The cold steam variety is preferred because the suspended molecules are smaller. Nasal mucus is 95% water and humidified air is the best diluent for concentrated mucus which is characteristic of many types of rhinitis.

The ideal nasal medication should simulate normal nasal secretions. It should be isotonic, slightly acid, and nonirritating.[4] Oily solutions may act as lubricants and decongestants, but they are heavy and impede ciliary action.

The preferred method of application is the nebulizer or spray. The nozzle should be directed toward the inferior and middle turbinates, and several applications may be necessary for the medication to reach the posterior nose.

The drop method, even with head positioning, does not disperse the drug over the most congested areas, and gravity favors the rapid flow into the nasopharynx.

Packs or pledgets soaked with medication assure prolonged contact and greater local therapeutic effect, but the trauma caused by the application may erode the inflamed membrane and interrupt ciliary activity. Gentle manipulation is recommended for any intranasal packing.

Local Anesthetics. Topical anesthetics are used frequently for major and minor nasal surgical procedures. This highly vascular mucous membrane is easily anesthetized, but vascularity increases the likelihood of systemic absorption and toxic reactions. For this reason, one must always use the recommended dosage and be prepared to manage any adverse effects of the drugs.

Cocaine in 2.5% to 10.0% concentration is preferred by many rhinologists because the vasoconstriction induced by this drug lessens systemic absorption. Tetracaine hydrochloride (Pontocaine) in 0.5% to 1.0% concentration is equally effective as a local anesthetic but lacks the vasoconstrictive action. Dyclonine (Dyclone) is a useful topical anesthetic prepared in 0.5% to 1.0% concentration. It does not produce the degree of anesthesia obtained with the -caine derivatives, but its toxicity is less and larger doses can be used. However, sensitivity precautions should still be used, and application to inflamed or edematous mucous membranes should be avoided.

Antibiotics. Topical antibiotics are of little or no value in the treatment of rhinitis and sinusitis. The contact with the diseased area is limited by the mucus blanket covering the nasal mucosa, and there is the possibility of inducing a sensitivity reaction. Van Alyea[4] noted the ineffectiveness and production of anosmia with these agents.

Astringents. The popularity of topical astringent drugs in the form of decongestants and vasoconstrictors has been declining in recent years due to the inherent rebound phenomenon, the risk of developing rhinitis medicamentosa, and the availability of more effective systemic drugs. Systemic medication will induce decongestion in areas inaccessible to topical drugs and produce a more gradual and prolonged effect.[5, 6]

For marked nasal congestion in acute phases of rhinitis and sinusitis, topical preparation of phenylephrine (Neo-Synephrine), ephedrine, and tetrahydrozoline (Tyzine) can be employed.

The newer vasoconstrictors, oxymetazoline (Afrin) and xylometazoline (Otrivin), exert a therapeutic effect for 8 to 12 hours and appear to have a low incidence of rebound congestion and chemical rhinitis. However, excessive use of any of these drugs may cause a congested mucosa with impaired ciliary activity. This entity is known as rhinitis medicamentosa.

Steroids. Topical steroids have not been very effective as nasal medication. Some authorities have recommended local injections into hypertrophic turbinates and polyps, but the limited duration of the shrinkage raises doubt as to its value as a therapeutic procedure. If the steroids are indicated in allergic disease, they should be administered systemically.

Antihistamines. Antihistamines, like the sympathomimetic decongestants, are more effective systemically than topically. The mode of action is the blocking of the release of histamine, a potent vasodilator. The efficacy of these drugs has been shown in studies by Pullen and Montgomery[7] and Aaronson et al.[8] These drugs give side effects such as drowsiness, lethargy, dizziness, and headaches.

Escharotics and Cautery. Escharotics are frequently used in the nasal cavity for epistaxis. The common sites of bleeding are the anterior inferior septum, the prominence of a septal deviation, and the posterior inferior meatus. The bleeding vessel may be an arteriole or a venule. Bleeding usually requires an escharotic and packing. Posterior arterial and venous bleeding is best controlled by posterior and intranasal packing because the bleeding point is not accessible to local cautery. The mode of action of escharotics is the occlusion of the open vessel wall by a coagulum of tissue necrosis. A clot then forms in the vessel wall at the site of the cautery.

Chemical caustics are silver nitrate, chromic acid, and trichloroacetic acid. The technique of application is concentric ringing of the bleeding point. Simultaneous use of suction to remove the blood from the cauterized area is advantageous. Once the bleeding is partially controlled, local packing for several minutes may stop or slow it down so that a second application of cautery can be more accurately placed.

Thermal cautery is equally effective in the treatment of nasal hemorrhage if the bleeding point can be visualized. The use of simultaneous cautery and suction is the preferred method, and again the ringing of the bleeding point is recommended.

Oxidized cellulose (Oxycel), gelatin sponge (Gelfoam), and alpha-cellulose (Surgicel) are hemostatic agents which can be applied effectively to diffuse areas of bleeding. Pressure should be exerted on the cotton or gauze packing. Oxycel tends to fragment when it ages. Gelfoam swells rapidly and is difficult to hold in place. Surgicel in sheet form can be wadded as a pack or wrapped around cotton or gauze.

Oropharyngeal Agents

Topical medication applied to the oral cavity stimulates the secretion of saliva, dilutes the concentration of the drug, and initiates the involuntary act of swallowing.

Lozenges or troches have limited action because they are sialogogues causing the dilution of the drug concentration. However, they dissolve gradually and their active ingredients are dispersed throughout the oral cavity and pharynx.

Mouth washes are effective in diseases of the oral cavity because the contact of the drug with the diseased area can be maintained.

The gargle brings the medication into contact with the upper pharynx. The head must be hyperextended for the gargle to be effective. Even then, contact of the medication with the diseased area in the lower pharynx is limited.

The throat irrigation instilled into the oropharynx by nursing personnel is a more effective means of applying topical medication to the pharynx. Two to three minute contact with the diseased area is maintained before the patient is allowed to expectorate.

The throat swab has a limited effect as a therapeutic procedure. Any medication applied to an inflamed pharynx coated with mucus and saliva barely makes contact with the diseased area and only remains there a short time. However, topical medication to discrete pharyngeal lesions has some merit. The area should be cleansed and dried before the drug is applied.

The nebulizer or spray is used for topical analgesia prior to endoscopic procedures. It is an effective means of dispersing the anesthetic throughout the pharynx and larynx.

Topical anesthesia in the oropharynx relieves mild pain associated with nonspecific inflammation. Local infiltrative anesthetics or parenteral analgesics are necessary to relieve moderate or severe pain. Ethyl aminobenzoate (Benzocaine) troches and lidocaine (Xylocaine) viscous have been useful agents, but occasionally allergic sensitivity reactions occur.

Prior to laryngoscopy, bronchoscopy and esophagoscopy cocaine in 4% to 10% concentration in pledget or spray form gives significant analgesia. Tetracaine in 1% concentration is also a potent and local anesthetic but the lack of its vasoconstrictive action may favor systemic absorption and a toxic reaction. Dyclonine hydrochloride (Dyclone) is a newer, safer, but less potent topical agent which can be used in larger amounts.

Acute bacterial infections of the oropharynx are best treated with systemic and not topical antibiotics. Chronic inflammatory diseases may not respond well to systemic medication, and may require local extirpative measures such as cautery and excision.

Specific topical anti-inflammatory therapy is indicated in some diseases of the oropharynx. Vincent's stomatitis and pharyngitis can be adequately treated by oxidizing agents such as sodium perborate and hydrogen peroxide. Fungus infections, usually caused by Monilia albicans are benefited by mycostatin (Nystatin) emulsion, 1% gentian violet, or amphotericin lozenges.

Escharotics are used on aphthous or herpetic ulcerations and inflamed lymphoid follicles. They relieve pain by forming a crust and combat infection by causing necrosis and atrophy of lymphoid tissue. Silver nitrate, chromic acid, trichloroacetic acid, and thermal cautery can be used. Chemical escharotics such as tannic acid were formerly used for hemostatic purposes in post-adenoidectomy and -tonsillectomy hemorrhage. Frequently, bleeding could not be stopped with these agents. Ligatures are the best means of controlling bleeding from tonsillar fossae, and thermal cautery and packing are recommended for adenoid hemorrhage.

Summary

Under proper approach topical medication applied to the ears, nose, and throat has therapeutic value. Numerous drugs, including antibiotics, vasoconstrictors, analgesics, anesthetics, and the like, are worthy of consideration. Maximal effectiveness is obtained by local cleansing measures preceding therapy. Caution should be taken as to the possibility of the development of undesirable side effects and sensitivity to these agents. □

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PROGNOSIS FOR SURVIVAL AFTER STROKE

P. P. LA TORRE, JR., MD and R. W. BOYLE, PhD, MD, Milwaukee General Hospital, Milwaukee, Wis.: *Geriatrics* 23:106–111 (Oct) 1968

This retrospective study of 669 consecutive stroke victims was undertaken to determine if any of the data commonly available from the admission history and physical examination would be useful in predicting the survival of the individual stroke victim. The fates of 653 of these patients 5 to 11 years later were compared with the following admission parameters: sex, race, respiratory rate, systolic and diastolic blood pressure, pulse pressure, deep-tendon reflexes, history of prior CVA, type of current stroke, pulse rate, systolic-diastolic ratio, age, and temperature. Only the last parameters proved to be of useful prognostic significance, especially age (a very poor prognosis confirmed for those 70 years old or greater) and admission temperature (a 100% death rate found in those with an oral recording of 101 F or greater).

W. D. James, M.D.

PRESIDENT'S PAGE

A Doctor's Dream, A Community Inspired

IN THIS DAY AND AGE it is much more common for communities to solicit Federal funds for local facilities than it is for them to make any attempt to provide for their own needs.

On March 2, 1969, it was my privilege to attend an Open House at the Ripon Cerebral Palsy and Rehabilitation Center. It was a tremendously stimulating experience to be guided through the new facility by the doctor whose dream had become a reality.

Some 15 years ago the doctor had a grandson with cerebral palsy. This provided the impetus for him to become more knowledgeable about the crippling affliction and he began to care for others with the same problem.

In 1959, inspired by the need for facilities for the care of the cerebral palsied, this doctor, his wife, and a few other interested local citizens incorporated a non-profit organization.

In 1961, this was converted, by invitation, into a community organization with a 9-member board of directors, supported by a 15-member advisory committee.

The scope of the organization was widened to include rehabilitation of patients recovering from cerebral vascular accidents and those who have had orthopedic accidents.

The center now offers physical therapy of all types, occupational therapy, day care services for the mentally retarded, training in motor skills and coordination. It offers vocational testing, work evaluation, and work tolerance tests. It also does hearing evaluation and speech therapy.

Physicians, members of the board of the Cerebral Palsy and Rehabilitation Center, and citizens of Ripon who provided the financing for the beautiful building and excellent equipment are deserving of our most sincere congratulations. The results of their efforts will be of inestimable value to their community. Their courage and determination in meeting a need and providing services without soliciting Federal funds serve as an example and inspiration in this era of dependence on government hand outs.

W. D. James MD

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Brickbats . . .

■ WILBUR J. COHEN, outgoing secretary of the Department of Health, Education and Welfare, tossed a hot potato to his Republican successor, and in so doing, he set up conditions that may seriously affect the very structure of the Medicare program.

By law, the Secretary is required to promulgate the rate for Medicare Part B, Supplementary Medical Insurance Premium. The rate he announces applies to the next fiscal year, which, in this case, is July 1, 1969, to June 30, 1970. The current rate is $8.00, half of which is paid by the beneficiary, and the other half by the government. The new rate must be announced by December 31st preceding the next fiscal year, and on that date Mr. Cohen surprised everyone with his decision to carry on with the same premium.

When Medicare was begun in 1965 the monthly premium was $6.00, split half and half by the beneficiary and the government. The rate was increased to $8.00 for the period 1968 to 1969, a 33⅓% increase. All that was requested this year, in the face of continuing price increases throughout the economy, was a 10% increase to $8.80.

The increase was recommended by the chief actuary of the Social Security Administration, Mr. Robert J. Myers, who indicated he would have felt even more comfortable with a greater hike. He told Cohen that physicians' fees will continue to rise, although at a reduced rate, and medical utilization under the Medicare program would probably increase by 2% in 1969 and another 1½% in 1970.

In his news conference on the subject, Cohen admitted that he too believed an increase in the rate was indicated. He had the advice of the Director of the Bureau of the Budget, the Commissioner of Social Security, the top staff of the SSA charged with administration of the Medicare Program, and representatives of physicians, nurses, economists, management, labor, and consumers. In the face of this formidable array of experience and talent, he chose to keep the SMI premium at the old rate.

Ex-Secretary Cohen's reasons for promulgating the $8.00 rate should not be dismissed lightly. They are evidence of a questionable sense of fiscal responsibility and an improvident balancing of possibilities and realities. The first undeniable fact he had to face was the limited means of many people over 65.

The higher rate would also result in an increase of about $100 million for the fiscal year in the Federal general revenue budget, and Cohen says he was "reluctant to saddle them with such a burden so early in their adminstration," the "them" being Nixon, Finch, and the Republicans.

Additionally, the states would have to pay the higher premium for their public assistance beneficiaries for whom they "buy-in." But most significant is Cohen's contention that an increased premium would have an inflationary effect on the entire medical economy because it would be interpreted as a minimum prediction of increase approved by the government.

Cohen's appraisal of the situation is probably honest, and most beneficiaries and suppliers of health care would be sympathetic to his anti-inflationary stance. But the alternatives to the increase are so frightening that one wonders whether a moderate increase now wouldn't have been preferable to the problems created by holding the line.

The Medicare program is now or will shortly be operating in the red under the $8.00 premium. With the most efficient use of physicians' services and the most diligent review of claims, the total cost of medical care under the program will increase as a result of the growing number of people covered by the program and the present inflationary character of our economy. In the unlikely event that physicians' fees do not rise in the next 18 months while everything else is going up, Medicare will still be hopelessly in the hole and the Republicans will be faced with the onus of a much larger increase for the 1970–1971 period, of cutting services or of asking the Congress to act to save the program. The Republicans will then be stuck with the responsibility of making a change in the program that could alter its essential character.

Congress could legislate regulation of physician's charges under the program, or it could, as Cohen has suggested, merge Part A and Part B and fund the entire program from general revenue sources, a solution that would spread the cost of Medicare more heavily on all taxpayers. Either way, the Republicans are stuck with a nasty situation that can result in nothing but irritation on the part of voters.

In implementing his good intentions, the departing Secretary of HEW has opted for a set of unfortunate consequences. He has made the medical profession appear conspicuous as profiteers if they don't keep their fees at the present level, and he has forced the Nixon administration to face a situation that can't be corrected except with inflammatory action. Instead of gradual increases that might have preserved the system as it is now, he has created the necessity for greater, perhaps drastic, increases later.

In refusing to promulgate a 10% increase now, ex-Secretary Cohen, whatever his reasons, didn't do a favor either to the country or to the medical profession.—D.N.G.

. . . and kudos

WHATEVER ELSE he did to jeopardize the future of Medicare, Wilbur J. Cohen, former Secretary of Health, Education and Welfare, protected it against the latest attempt of the cultists to latch on to a bonanza.

As one of his last acts, Cohen recommended that chiropractic services to the aged not be compensated by Medicare. He reported to Congress that "chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community." He also pointed out that "the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment."

What Cohen left unsaid is how much it would have cost the aged and the federal government if that chiropractic corps of cultists got their snouts in the public trough by taking advantage of the lack of scientific sophistication of many of the elderly. Nor did he mention that the door would be left open for the qualification of even less savory "healers" for public funds.

At the present time chiropractors are licensed to practice in 48 of the 50 states. It is high time that the individual states recognize what the Department of HEW knows about chiropractors. A movement should be started to de-license the cultists.

Licensing chiropractors gives them a balloon of respectability which they quickly fill with pseudo-scientific hot air. By puncturing that bag, the legislatures of the states can do much to safeguard the health of the community, and certainly save its money.

Wisconsin should take the lead in de-licensing and keep itself in the front rank of the states that show a genuine concern for the health and well-being of all its citizens.—D.N.G.

The Index Medicus and MeSH

By VIRGINIA HOLTZ, Madison, Wisconsin

WHEN TODAY'S BUSY practitioner thinks of medical indexes at all, he usually conjurs up a mental image of shelves filled with a long unbroken set of volumes. Indeed, the entity commonly known as "Index Medicus" is actually a series of sets issued under more or less similar titles in an unbroken line since 1879 (see History Chart).

It was started by Dr. John Shaw Billings of the Surgeon General's Office in 1879. Even in those days of relatively few medical publications, the indexing of the world's medical literature was an awesome job. It became apparent that the dedication of a few men could not withstand the flood of scientific literature of interest to the medical community. Throughout the years a branch of the United States Government or the American Medical Association (AMA), or some combination of the two, have provided some kind of medical index for the use of the world medical community.

Though it is reassuring to know that we can trace medical literature back through this series in an unbroken line to the year 1879 and can make some attack on even earlier years through the *Index Catalog of the Surgeon General's Office,* the most important segment of this group for today's practitioner is the current series which originated in 1960.

In 1957 the National Library of Medicine (NLM), which was then publishing the *Current List of Medical Literature,* began to explore mechanical methods which would assist in the indexing tasks. In 1959 the American Medical Association was invited to join in a cooperative effort, allowing the then sadly delayed *Quarterly Cumulative Index Medicus* to come to a complete halt with its 1956 volume. It was agreed that the National Library would index the material and issue the monthly *Index Medicus* and the AMA would tackle the production of an annual cumulation of the twelve issues. The first volume under this joint sponsorship appeared in 1960.

Meanwhile, the NLM continued to investigate the more sophisticated forms of mechanization which would yield a better product, and in 1964 MEDLARS (Medical Literature Analysis and Retrieval System) was born. The National Library assumed complete responsibility for the whole operation in 1965.

For those used to the two older indexes, the new one presented some challenges. Since the system was basically designed for machine-oriented searching by a process of coordinating terms, and since the index vocabulary was in many cases quite different from that used in the earlier products, there was a certain amount of "cultural shock" involved in the transfer. This was especially true in the three years during which no subheadings were used (1963–1965). The machine could locate the required articles with ease by searching under the various terms, the sum of which described the desired concept, and by picking only those items which appeared in *all* of the required listings. A manual search using the same technique was exhausting. Even precoordinate terms such as COLD CLIMATE (rather than COLD and CLIMATE) and THORACIC NEOPLASMS (rather than THORAX and NEOPLASMS) left the index with many headings under which pages of citations appeared with no subdivisions. In 1966 the subheadings were reintroduced, much to the joy of the visual searcher, since the subheadings served to sort the citations, under the popular main terms, into more easily managed—and more specific subgroups.

Reasons for Use

Although a great deal of time, money, and effort go into the production of this improved *I.M.* each year, whole segments of the health science population fail to use it from one year's end to the next. The academically oriented medical communities, the medical centers, the urban hospitals with university affiliations, and the larger clinics and research-minded hospitals almost inevitably have *I.M.* In these settings there is usually a library and a librarian to facilitate its use. In the smaller community hospitals, in clinics and in private practice, the direct use of this major information tool is minimal.

While the differing informational needs of these two major groups explains in part the differences in use, another major factor is simple unfamiliarity with the many facets of this versatile index and the techniques for its efficient use. Many physicians from both camps developed their

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information-seeking techniques at a time when all of the literature relevant to their problems could be found in either the major general medical journals, such as the *J.A.M.A.* or in their few specialty journals. For many years this remained an adequate and serviceable approach to the literature. As the nature and amount of health-related literature have changed, however, so the effective method of approach has altered.

If the information seeker must check the individual yearly indexes to two general and two specialty journals to find the information he needs, a five-year search will entail the use of 20 separate indexes—time-consuming but not impossible or even impractical, if all of the issues are where they belong. Today, however, the same sort of subject search may entail searching twice as many journals, some of which may have enlarged to the point where they issue several indexes per year. This could mean a search of 40 indexes at least. Since the vast majority of the journals concerned would doubtless be indexed in *Index Medicus,* the same survey could be made by checking one cumulated index for each year to be searched, plus whatever monthly issues of the *I.M.* were available for the current year. Not only does this result in a great saving of time but also it offers the bonus of relatively complete coverage of the subject of interest as it appears in *all* major and many minor medical publications throughout the world.

In these days of interdisciplinary research, specialty journals are no longer as all inclusive nor as mutually exclusive as they once were, making this additional benefit one of real importance. The searcher using an index which includes the material from hundreds of journals, can be more certain that some relevant literature has not escaped his notice because of where it appeared in print. This use of a major index as a current awareness device is often not recognized. Not only can the simple scanning of titles be of real help in keeping up to date on what is being done in a field but also the regional information networks going into operation insure that all physicians, regardless of location, have access to a large percentage of all published medical information when they need it.

Index Medicus Format

The index itself is a relatively straightforward tool. In some ways it is like a good car; easier to use once you understand a little about how it is put together and how its designers intended it to be used. It is available in two formats. One can subscribe to either or both, depending on need. The most current and up to date section is the *Index Medicus,* a monthly paper-bound issue of approximately 700 pages containing those citations put into the system in the preceding month. These citations, currently, are to journals issued approximately 3 to 4 months previously for domestic journals and 12 to 24 months for foreign titles. In each issue there are several distinct divisions: a subject section in which citations are grouped under subject headings; a name section where material is listed alphabetically according to the names of people who wrote articles or about whom articles were written; and the Bibliography of Medical Reviews, which is a separate author/subject index to review articles (these citations also appear in the main subject section but are printed as a sub-set for the convenience of those wanting only review articles). The current subscription price is $63.00 per year.

CIM Format

While the monthly issues of *Index Medicus* meet the demand for a CURRENT medical index, its use becomes burdensome and time-consuming as the issues pile up. To solve this problem the *Cumulated Index Medicus* is issued annually, usually in about April of the following year. This three-to-five volume set presents in cumulated form all of the material previously available in 12 separate alphabets in the monthly issues. In addition to reducing the number of places to look by a factor of 12, additional assistance is offered in the form of cross references from unused subject headings to used ones and from one related heading to another. These cross references do not appear in the monthly issues.

These compact volumes also contain a cumulated "Bibliography of Medical Reviews", the "List of Journals Indexed in Index Medicus", and "Medical Subject Headings." The current subscription price is $72.25 per year.

MeSH

The step-child of *Index Medicus* is the black supplement to the January issue (it also appears in the *Cumulated Index Medicus*), known as *MeSH.* This section is often found dust-covered, but otherwise in mint condition when the rest of the monthly numbers have long since shown the normal signs of wear and tear. This fate is undeserved since *MeSH,* or *Medical Subject Heading,* to give it its full title, when properly used, can provide the key to the rest of the Subject section.

Officially, it is the National Library of Medicine's technical language. The terms listed in it are those used in indexing biomedical journal

Dates	Name	Sponsor	Format	Scope
1879–1926	Index Medicus	Library, Surgeon General's Office	Monthly with annual author and subject indexes	All current medical journals which could be obtained
1916–1926	Quarterly Cumulative Index	American Medical Association	Dictionary arrangement	326 periodicals
1927–1932	Quarterly Cumulative Index Medicus	A.M.A. and Army Medical Library	Dictionary arrangement	1,165 periodicals in 1927
1932–1956	Quarterly Cumulative Index Medicus	A.M.A.	Dictionary arrangement	905 periodicals 60,000 articles annually
1941–1950	Current List of Medical Literature	National Library of Medicine	Weekly list of contents of...	"Some of the more useful medical journals" received in the National Library of Medicine
1950–1959	Current List of Medical Literature	National Library of Medicine	Register of articles Author index Subject index	110,000 articles annually
1960–1964	Index Medicus and Cumulated Index Medicus	N.L.M.—Monthly A.M.A.—Annual	Author section Subject section	125,000 articles in 1960
1965–	Cumulated Index Medicus and Index Medicus	National Library of Medicine	Name section Subject section	165,000 articles in 1967

articles, and conversely, in searching the finished index. It is issued annually because it is part of a young and changing system and because it reflects the dynamic nature of the science for which it is attempting to provide bibliographic control. In the 1968 revision alone, 675 new headings were introduced. *MeSH* is the one place where the *Index* user can find all of the terms currently available displayed in their various relationships to each other and to the system.

The first part of this special issue is made up of an alphebetical list of all of the terms. Besides the terms themselves, it also contains cross references from unused to used words, from general to specific terms, and from one used term to another which might cover related material. A typical listing is:

HERNIA (C4, C17)
see also related
TRUSSES (E4)

After each descriptor is an alphanumeric designation in parentheses. These designations refer to the Categorized Lists in the second section of *MeSH*. In the case of the HERNIA heading listed above, the "alpha" C refers to all "Lists" dealing with diseases while the "numerics" 4 and 17 refer to tables representing the more specific subsets, "Digestive System Diseases" and "Symptoms and General Pathology." Each term in the MEDLARS system appears on one or more of the 69 tables currently available. Every term delegated to a certain table appears there in its proper alphabetical sequence. Here it may have indented under it more specific headings relating to the same concept. In addition it may appear indented under a broader term to show a further relationship, and to indicate to a searcher looking at the broad term that this more specific heading was available.

A further supplement to the alphabetical and categorized sections is the list of subheadings which may be used with the main terms. There are currently 60 of these helpful subdivisions and they are displayed in the introductory pages of each *MeSH* issue. A typical entry in this list appears as follows:

> Drug Therapy (C, F)—Used for the treatment or the prevention of disease by the administration of drugs, chemical and other therapeutic agents, such as antibiotics, biologicals, and tissue extracts. Excludes diet therapy.

The scope notes following each subheading are helpful in determining which of them would be useful. The letters in parentheses after the subheading indicate that Drug Therapy may be used with main headings taken from Categorized Lists in the C (diseases) and F (psychiatry and psychology) categories.

How to Use Index Medicus

The most common approach to the *Index Medicus* Subject Section is the trial and error method. Sometimes this is effective, and sometimes it is not only ineffective but also misleading. The secret of success when using the subject approach is to determine where the indexers at the National Library of Medicine have put citations concerning your subject. Enter *MeSH!*

It is the use of these tables and lists that really simplifies the use of *Index Medicus*. For instance, the searcher interested in a skin disease can turn to the C12 section which deals exclusively with the headings relating to this problem. By scanning the two pages of C12 one can see quickly

what headings relevant to skin diseases are available, rather than playing hide and seek through the 199-page alphabetical list. By using this method, he is not only assured of finding the right heading in the Alphabetical section of *MeSH* significant terms.

When selecting search terms, it is important to remember that the indexers put citations under the most specific descriptors available to them. For instance, when looking for material on inguinal hernia, one can turn to the HERNIA heading in the Alphabetical section of MeSH (see example above). Having noted that additional material may appear under the heading TRUSSES, the searcher should then turn to the table C4 and there find the listing:

HERNIA (C17)
- Diaphragmatic Hernia
- Femoral Hernia
- Inguinal Hernia
- Umbilical Hernia (C16)
- Ventral Hernia

It is immediately obvious that INGUINAL HERNIA is an ideal term for this search. A quick glance at the rest of the headings on the four-page C4 list (Digestive System Diseases) shows that no other headings would contribute to this project. A check of the heading INGUINAL HERNIA where it appears in the alphabetic sequence of table C4, as distinct from above where it appears indented under HERNIA, shows that the INGUINAL HERNIA is not further subdivided. To be absolutely sure that nothing has been missed, the searcher should also check table C17, the second table on which the heading HERNIA appears. A quick check reveals that no additional terms are listed there. Since INGUINAL HERNIA is not followed by any additional alphanumeric designations, this means the end of the line has been reached. Once this trick has been mastered, it is quickly applied to any search.

With a list of the necessary headings at hand, the searcher can approach the subject section of *Index Medicus* with confidence. Using his selected terms and subheadings, he can examine the citations listed there. All of the English language items are given first, arranged alphabetically by journal title, followed by the foreign language articles grouped alphabetically by language.

Each citation is made up of the following elements: original English language title or English translation of the foreign language title, senior or sole author's name, journal title abbreviation, volume number, inclusive pagination, date of issue, and an abbreviated language symbol if the article is in some language other than English.

Citations are indexed under an average of three headings, although a particular article may appear in more or fewer places depending on its content.

When tracing the literature of a subject back over a number of years, the searcher will sometimes find that a fruitful heading suddenly is no longer used in the *Index*. Starting in 1966, *MeSH* contains two additional helpful devices; a table of new headings, which also lists the major terms under which material on the subject formerly appeared; and a table of deleted headings paired with their replacements. For years prior to 1966, it is usually best to try either a synonym or the next most general heading.

If the searcher is interested in articles by a specific person, he should use the Author (1960–1963) or Name (1964 +) Sections. Here the full citation is listed in the original language after the first author's name, with cross references from the second and third authors. Should a senior research worker, in whose published articles our theoretical searcher is interested, customarily appear as the last of a long string of contributors, his name will not appear in this index and some other tool will have to be used.

Since 1964, the Name Index contains biographical material as well. Items of this nature are listed here under the name of the biographee as well as the biographer. Names of biographees are distinguished from the others by being enclosed in parentheses. Anonymous biographies and obituaries appear only under the subjects' names.

This *Index Medicus,* like its predecessors, is a dynamic tool, and an essential adjunct to work of today's biomedical scientist. □

NEW TREATMENT OF SHOCK SHOWN IN UPJOHN FILM

A revolutionary concept and technique—treatment of shock by vasodilatation—is depicted in a new film, "Lillehei on Stagnant Shock," the seventh in The Upjohn Company's award-winning Vanguard of Medicine Series. The film is available free to professional groups from Upjohn's Professional Film Library.

Contrary to earlier opinion, the film shows that severe shock almost always involves a marked reduction in peripheral circulation. The new term, "stagnant" shock, was chosen to describe the condition, which is shown to respond to various procedures and drugs intended to achieve vasodilatation.

The 16mm film is available without charge for showing to members of the medical and allied professions through the office of R. P. Trubey, manager of Special Projects for The Upjohn Company.

the wisconsin medical journal

VOLUME 68/NUMBER 4 APRIL 1969

Screening the Cranial Vault and Its Contents by Scanning with Technetium 99^m

By MARVIN H. OLSON, M.D. and RUSSELL C. BRIGGS, M.D.
Madison, Wisconsin

■ THE DIAGNOSIS of the etiology of various central nervous system dysfunctions is often very tedious and uncertain. The usual complete neurological examination is performed. Following this, various adjuvant diagnostic procedures are carried out. Some of these are accompanied by a certain amount of morbidity. Screening the cranial vault with technetium 99^m is an innocuous procedure and often gives very helpful and interesting additional diagnostic information.

Technetium 99^m is a useful radioisotope for brain scanning because of its short physical half-life (6 hours). This permits use of high doses providing large photon flux with low radiation absorbed dose. It is chemically free from toxicity and there is no morbidity and no mortality associated with the scanning procedure. Its concentration in the blood pools in and around the cranium and its contents serves to demonstrate the normal anatomy, as well as variations caused by vascular and other nonmalignant conditions, as will be presented in this report.

Methods and Materials

The radioisotope used in all cases was technetium 99^m (99^m Tc). This was prepared daily by elution from a molybdenum 99-technetium 99^m generator with isotonic saline. The intravenous dose, administered usually at the antecubital site, was 100 μCi/Kg body weight, with a maximum dose of 15 MCi and a minimum dose of 2.5 MCi given approximately 10 to 15 minutes prior to scanning. The scanning was done with an Ohio nuclear rectilinear scanner. We employed the Model 54 FD with dual opposed 5 inch sodium iodide (thallium-activated) crystals. Four views were made in each case: anterior, posterior, right, and left lateral. Scanning was completed in 15 minutes.

Results

Activity (radioactivity) displayed in the normal cases is intravascular in location. Abnormalities are detected by deviation from the normal as displayed on the scan. Thus, we see activity normally in the venous sinuses, nasopharynx, diploe, meninges, and superficial arteries. These are well illustrated in Figure 1. Note especially the appearance of the superior longitudinal sinus in the anterior view; confluence of sinuses and lateral sinus on the lateral view; and the longitudinal, lateral and straight sinuses, and the confluence of sinuses on the posterior view. The anatomic features of a normal brain scan were well demonstrated in a recent article by Weber.[1]

Abnormalities Noted in 99^m Tc Scan

1. Displacement of normal vascular structures: arachnoid cyst.

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μCi = microcuries.

MCi = millicuries (average white body radiation dose for a brain scan is about 0.29 rads).

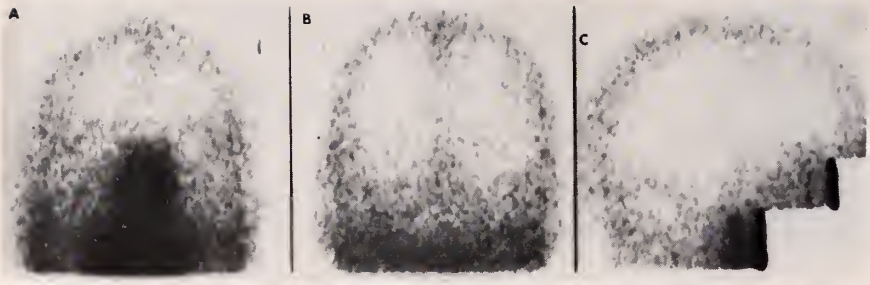

Fig. 1—A normal brain scan: (A) anterior view, (B) posterior view, and (C) lateral view.

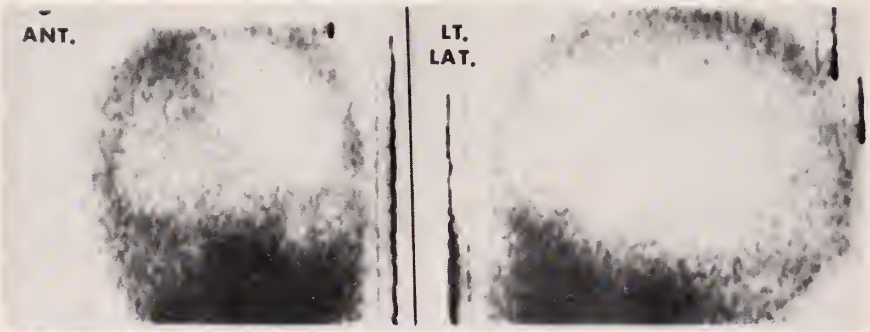

Fig. 2—Case 1: Anterior view of brain scan shows shift of area of normal activity to the right with a large area of decreased activity on the left. Lateral view shows large area of diminished activity over anterior five-sixths with normal activity posteriorly.

Fig. 3—Case 1: Roentgenograms show a large cystic mass displacing normal structures anteriorly and to the right.

2. Presence of abnormal vascular pools: (a) arteriovenous malformation, (b) fibrous dysplasia, and (c) neoplasms with new vessels.

3. Abnormal blood-tissue interface: (a) inflammation—cerebritis, (b) traumatic—subdural hematoma, and (c) degenerative—stroke.

Illustrative Cases

1. Displacement of normal vascular structures: *Arachnoid cyst*

The normal pattern of vasculature may be changed by extrinsic factors resulting in a change of position and/or configuration of vessels. These changes may not result in damage to the "blood-brain barrier," although it is conceivable that such damage could occur if necrosis resulted from pressure. Five cases of intracranial cysts with positive brain scans were reported in 1968 by Mishkin and Truska.[2]

Case 1. A one-year-old boy was hospitalized because of the development of a large soft mass on his head. Motor milestones were normal. Air studies at six months suggested a shift of the right lateral ventricle to the left. His occipital frontal circumference was 54 cm and there was a soft protrusion over the left temporoparietal area. The brain scan demonstrated a shift of the sagittal sinus to the right. Brain tissue on the right showed normal

activity while there was diminished activity on the left (Fig 2). Also on the left lateral view there appeared to be some normal vascular activity posteriorly, but the anterior five-sixths of the brain showed diminished activity. This was consistent with a large nonvascular space-occupying lesion in the left hemisphere. Roentgenograms with contrast media showed the presence of a large cystic mass displacing normal structures laterally (Fig 3).

When craniotomy was performed, a large arachnoid cyst was found and a cystic peritoneal shunt with Pudenz valve was completed. The shunt was later revised. The patient did well postoperatively and was subsequently discharged.

2. Presence of abnormal vascular pools:

(a) Arteriovenous malformation

Figure 1 showed the activity in the normal pools. Case 1 illustrated a shift due to an anatomical change in position. Abnormal variations within the vasculature structure are seen in cases of arteriovenous malformation. This may also occur in fibrous dysplasia and in certain neoplasms with new vessel formation.

Case 2. A 28-year-old man was hospitalized for evaluation of seizure disorder and known A–V malformation. He had a soft blowing bruit over the left orbit and mild bilateral nystagmus. The skull x-ray films revealed localized thinning of the cranial bones overlying the area of malformation in the left parietal region (Figs 4 and 5).

The brain scan showed a lesion in the left posterior parietal area. It revealed a definite focus of increased activity in the left posterior parietal area close to the brain surface (Fig 6). It was considered consistent with A–V malformation. The patient was subsequently treated with phenobarbital, diphenylhydantoin sodium (Dilantin), and deserpidine (Harmonyl).

(b) Fibrous dysplasia

In bone lesions of the cranium, such as fibrous dysplasia, there may be an increased amount of blood in the area due to increased vascularity. As a result, there is increased activity on the scan.

Fig. 4—Case 2: Radio-opaque media in the A–V malformation viewed through the left orbit.

Fig. 5—Case 2: Lateral skull film showing large A–V malformation in parietal area.

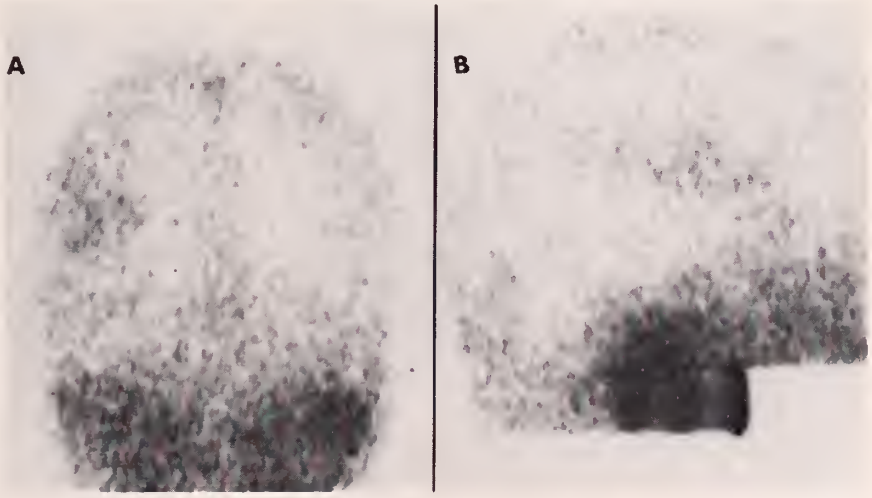

Fig. 6—Case 2: Scan shows increased activity close to the brain surface in the left parietal area consistent with a diagnosis of A–V malformation. (A) Posterior view. (B) Lateral view.

Fig. 7—Case 3: Large, circumscribed area of mottling due to sclerosis and fibrosis in a considerable portion of the frontal bone. Read as fibrous dysplasia.

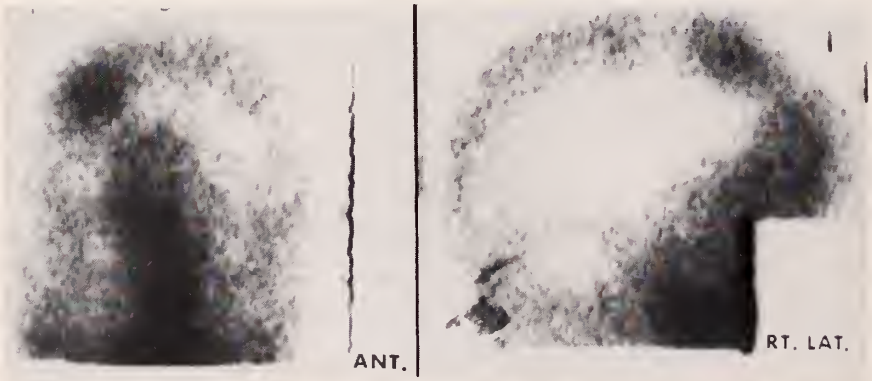

Fig. 8—Case 3: Marked increase in activity in region of right frontal bone due to increased, abnormal blood pool from marked vascularity of the dysplasia.

This locally increased blood pool due to the markedly increased vascularity of the unusual architecture is well demonstrated in fibrous dysplasia.

Case 3. A 27-year-old woman was referred to radiology because of a presumptive diagnosis of Paget's disease of the skull. There had been a gradual enlargement of the frontal bone, more on the right than on the left. The patient had a history of chronic headaches which started in the frontal region and radiated over the top of her head. On physical examination there was marked swelling of the forehead, more aggravated on the right side. There was marked sensory involvement in the distribution of the supraorbital nerves on both sides. The skull x-ray film showed a large well circumscribed lesion involving the greater portion of the frontal bone (Fig 7). It had a sclerotic border and expansion over the supraorbital areas. The general pattern was a mottled one with mixed areas of sclerosis and fibrosis. The conclusion was fibrous dysplasia.

The brain scan revealed markedly increased activity in the region of the frontal bone, more on the right than on the left side (Fig 8). This was thought to be due to an increased, abnormal blood pool which would be consistent with a diagnosis of fibrous dysplasia.

(c) Neoplasms with new vessels

Neoplasms with relatively large blood pools due to many new vessels show increased activity on the brain scan. This is particularly true in the case of vascular meningiomas and has been previously described.[3]

3. Abnormal blood-tissue interface:

(a) Inflammation—cerebritis

An inflammatory lesion of the brain can simulate a space-occupying lesion. This may be true even if the area is not encapsulated or in the form of a frank abscess. Aspects of the similarity can often be found in both the historical notes and the physical findings. This is seen in Case 4

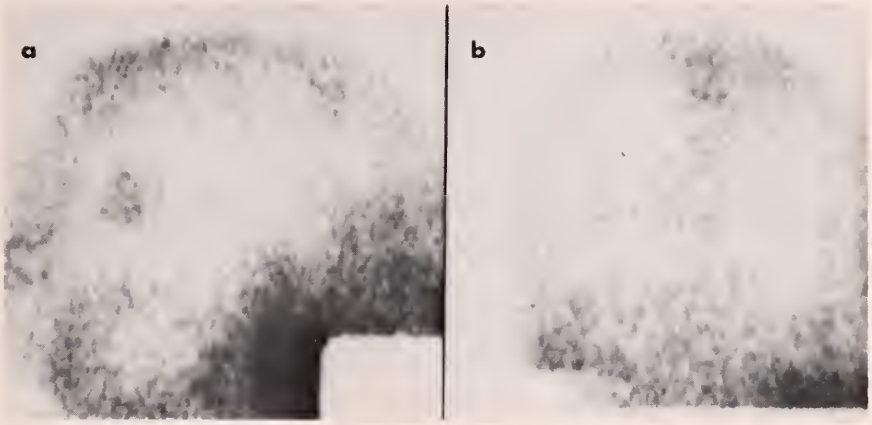

Fig. 9—Case 4: Multiple areas of increased activity due to multiple areas of gliosis and inflammation as seen on (A) lateral view and (B) posterior scan.

which was a biopsy-proven cerebritis. In this instance the increased areas of activity due to increased deposition of the radionuclide were due to areas of damage to the blood-brain barrier as a result of multiple foci of infection.

Case 4. This 45-year-old man was sent home from work after behaving strangely in a very belligerent manner. He was later found in his room, limp and unresponsive. Thereafter he was comatose for four days with a fever of 106 F. He was treated initially with antibiotics and steroids and later transferred to this hospital. He was restless and did not cooperate well but his improvement continued on conservative treatment. The cerebrospinal fluid contained 193 white blood cells per cu mm, glucose was 48 mg/100 ml, protein was 210 mg/100 ml, and chloride 116 mg/100 ml. No culture was ever grown.

The brain scan showed at least four lesions (Fig 9). There was a lesion in the right occipital area, another in the left parieto-occipital area, a third lesion in the left parietal region and a fourth lesion in the right frontal area. Most of these lesions were close to the brain surface and are suggestive of metastatic tumor. Other entities to be considered include multiple abscesses, multiple vascular malformation and meningiomata. The final impression was multiple space-occupying lesions in both hemispheres.

A right carotid arteriogram, pneumoencephalogram, and pneumoventriculogram were within normal limits. The electroencephalogram showed a generalized abnormality, nonspecific in nature.

A right occipital brain biopsy showed generalized inflammation. The histological report was focal gliosis and inflammatory focus. He subsequently improved and was discharged from the hospital.

(b) Traumatic—subdural hematoma

When blood is extravasated outside the vessels as in the case of a subdural hematoma, a characteristic finding is noted. This is illustrated by Case 5. A large crescent-shaped area of increased activity was seen, especially on the anterior or posterior view. No change could be seen on the lateral view in many instances.

Case 5. A 19-year-old man was hospitalized because of sudden onset of severe bitemporal headaches two days prior to admission. These were accompanied by nausea, emesis, and transient diplopia. History included a head injury in a football game four months earlier. Physical examination showed a somewhat enlarged right pupil, bilateral papilloedema, and small hemorrhages of the left disc. The spinal fluid pressure was elevated. Electroencephalographic studies raised the question of increased intracranial pressure. A right carotid arteriogram was compatible with left subdural hematoma (Fig 10).

Fig. 10—Case 5: Carotid arteriogram shows shift of vascular pattern of left hemisphere due to extrinsic pressure from subdural hematoma.

The brain scan showed a definite increase in the amount of radioactivity over the convexity on the left, as seen on the anterior and posterior views (Fig 11). The findings were considered to be consistent with a diagnosis of subdural hematoma.

A left subdural hematoma in the amount of 150 ml was evacuated via a left parieto-occipital and left frontal burr hole. The histological report also included vascular fibrous tissue.

(c) Degenerative disease—stroke

When a major vessel, such as the middle cerebral artery, is occluded by an embolus or thrombus, a fairly characteristic area of increased activity is seen as demonstrated by Case 6. In this

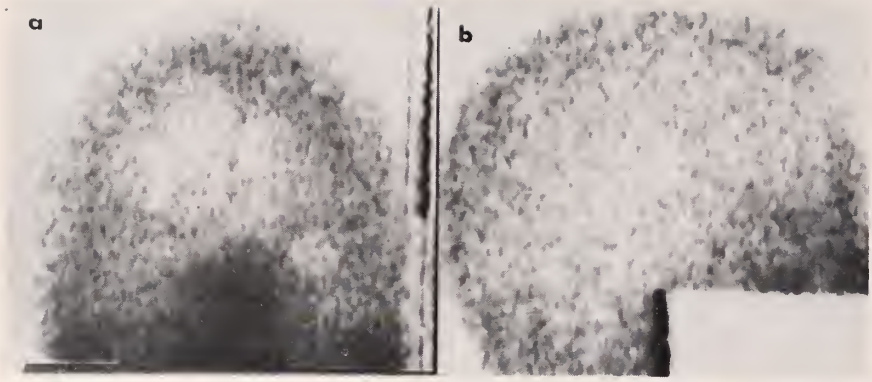

Fig. 11—Case 5: The typical "crescent" sign as seen on (A) the anterior scan of this subdural hematoma but is not demonstrated on (B) the lateral view.

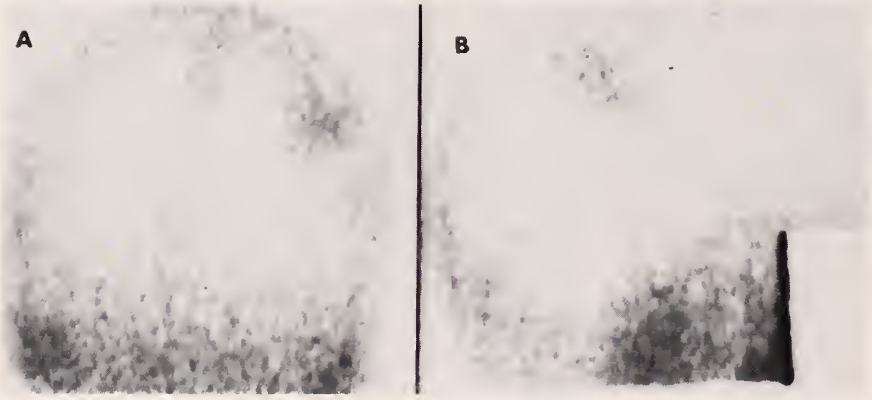

Fig. 12—Case 6: (A) Posterior scan shows a wedge-shaped area of increased activity which appears close to the surface in the left hemisphere. (B) On the lateral view the area is located in the parietal area. This was considered to be consistent with an area of infarction secondary to vascular accident.

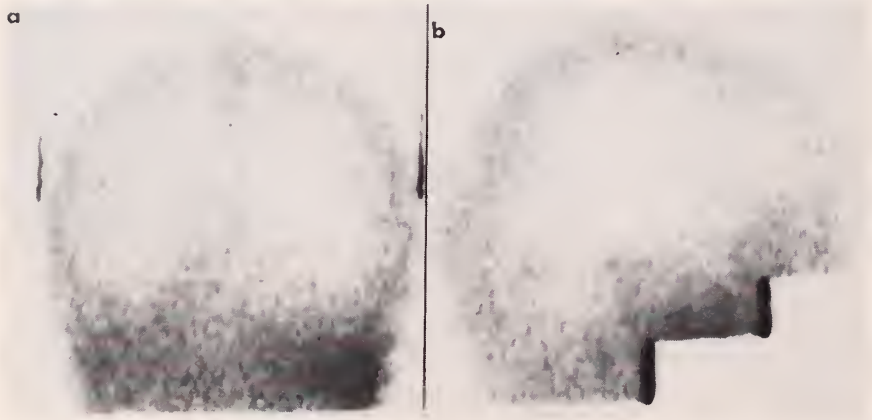

Fig. 13—Case 6: A repeat brain scan after six months shows a return to normal activity on both the (A) posterior scan and (B) the lateral view.

instance the infarcted area of the brain is represented by a wedge-shaped area of increased density due to higher concentration of the radionuclide in the affected tissue. This is presumably due to the breakdown of the normal "blood-brain barrier" with subsequent increased perfusion of the technetium into the area of infarcted brain tissue. This change is usually seen in 7 to 10 days after infarction and may disappear after several weeks as healing takes place.

Case 6. A 45-year-old woman, a nurse's aid, was hospitalized with a right hemiparesis and aphasia which came on suddenly a few days prior to admission. Her history included a painful left leg several days before the episode. She had never been hypertensive. Her blood pressure was 110/70 mm Hg. Physical examination showed both receptive and expressive aphasia, right lower facial weakness; general weakness of the right extremity. The impression was cerebral thrombosis, left hemisphere. Skull x-ray films were normal. The electroencephalographic studies showed evidence of focal cortical destruction in the left temporal region.

A brain scan showed a wedge-shaped area of increased deposition of the radionuclide in the left parietal region. On the lateral scan this appeared to extend close to the brain surface, and on the anterior and posterior scans the lesion was noted to be lateral in position and extended to the brain surface (Fig 12). The findings were consistent with a space-occupying lesion, most probably an area of encephalomalacia secondary to vascular accident.

A repeat brain scan after six months revealed normal distribution of radioactivity through the cranial vault and venous sinuses (Fig 13). The changes which were noted in the left hemisphere had disappeared. The sequential findings in this case are consistent with a vascular accident with subsequent healing.

Comments

When technetium 99^m is employed for screening the cranial vault and its contents, the distribution of activity in the normal blood pools has a characteristic pattern. Deviations from the normal picture by a shift or change in the pattern, with areas of increased or decreased activity, can be helpful diagnostic aids.[1]

When there is damage to the blood-brain barrier, areas of increased uptake appear in the brain. This may occur in infection, infarction, or tumor formation. Increased activity is also evident when increased vascularity accompanies tumor growth, as seen in some meningiomas, for example.[3]

The areas of activity may be shifted in cases where the vascular structures are displaced by a lesion such as an arachnoid cyst. Here there appears to be a negative defect with reduced activity because of the avascular nature of the cyst, as previously demonstrated by Mishkin and Truska.[2] The abnormality is due to displacement of the normal blood pool and change of configuration due to extrinsic pressure.

Other lesions which can cause a shift in the activity include porencephalic cysts and unilateral hydrocephalus.

There is increased activity on the scan when there are abnormal blood pools present. The increased activity in these areas reflects an increased amount of blood due to abnormality in the vasculature. This has been demonstrated in the scans of A–V malformations, in the increased number of vessels in fibrous dysplasia, and also where growing neoplasms are accompanied by new vessels. These changes also may be present in hyperostosis, Paget's disease, osteomas, and metastases.

The activity pattern resulting from an abnormal blood-tissue interface as a result of trauma may be very characteristic. In the case of subdural hematoma there is compression of normal brain by extra vascular blood with localized increased activity in fluid and membrane. This may present as a rather typical "crescent sign"—a large crescent shaped pattern of increased activity as seen on anterior and posterior views.

Other causes of the "crescent sign" include occlusion of the external carotid, absence of a bone flap, subdural empyema, chronic pachymeningitis, unilateral bone lesion, subgaleal hematonic, and scalp trauma.

In degenerative diseases as stroke there is localized increase in activity due to infarction or hemorrhage damaging the blood-tissue interface. The incidence of positive scans in strokes is estimated in a recent publication to be 56% in patients who had hemorrhagic lesions.[4, 5]

Summary

Technetium 99^m is a safe and useful radionuclide for brain scanning. For this reason it is valuable for screening the cranial vault for benign lesions as well as when the search is for suspected metastatic or primary intracranial malignant disease.

Several cases were presented primarily to illustrate its use in identifying various benign lesions. Brain scanning, as is true with most investigative procedures, is most helpful when correlated with other clinical and diagnostic findings. □

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The indication for coronary arteriography can be stated very briefly: unless another diagnosis is certain, and adequate to explain the patient's difficulty, subjects with recurrent chest pain which is aggravated by activity should have coronary arteriography. Although there are complications from this procedure, they are generally less than those of diagnostic cardiac catheterization. They are much less than the complications which occur frequently in the course of coronary artery disease, especially if it is undiagnosed. Unfortunately, until the present, there has been no objective way to evaluate therapy directed at coronary atherosclerosis, and consequently there are no established values. It has been shown recently by arteriography that myocardial revascularization can be accomplished, and that coronary arteries can be repaired successfully. Coronary artery surgery is palliative surgery directed at one particular aspect of a general arteriosclerotic problem, i.e., the relief of angina. Delaying or preventing an infarction can be hoped for. This is surely sometimes achieved with direct coronary artery surgery. Much more information is needed but a start has been made.

Coronary Arteriography and Myocardial Revascularization

By GEORGE G. ROWE, M.D. and WILLIAM P. YOUNG, M.D., Madison, Wisconsin

■ CLINICAL CORONARY arteriography is roughly ten years old. In the beginning, coronary arteriograms were achieved with considerable difficulty, but sufficient skill has now grown in many laboratories that the procedure can be accomplished expeditiously in most subjects, and adequate definition of coronary artery lesions is usually achieved.

In spite of its youth, a cooperative study conducted in 16 cardiac catheterization laboratories[1] revealed that about 3,300 coronary arteriograms were done in a two-year period extending from Nov. 1. 1963 to Oct. 31, 1965. It seems certain that many more coronary arteriograms would be done in a two-year period now than were done at that time. Indeed these data constitute a very small segment of the cardiac catheterizations done in the United States, and obviously a procedure which has become so popular in such a short period of time must have a great deal to offer. This paper will discuss the indications for its accomplishment, consider its risks, and finally describe the benefits which can be expected to be derived from its use.

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Doctor Rowe is Professor of Medicine and Doctor Young is Professor of Surgery.

This work was supported in part by grants from the National Institutes of Health, USPHS, National Heart Institute Grant Nos. HE 07754 and HE 14, 928.

Reprint requests to George G. Rowe, M.D., Cardiovascular Research Laboratory, 1300 University Ave., Madison, Wis. 53706.

Indications for Coronary Arteriography

The definition of angina pectoris has been clarified considerably by coronary arteriography. A repeatedly recurring pain in any part of the body from the belt upwards should be considered to be angina pectoris if it is clearly provoked by physical exertion, and predictably relieved in a few moments by rest. The diagnosis becomes more clear if the pain is closely associated with the sternal or substernal region, and if it is ameliorated in one to three minutes by sublingual administration of nitroglycerin. Additional features of aggravation after large meals, and occurrence during excitement or sexual intercourse make the diagnosis almost certain.

The presence of angina pectoris is an indication for coronary arteriography unless an acceptable cause such as valvular disease, hypertension, anemia, thyroid dysfunction or other general disease is present and adequate to account for the patient's symptoms without coexisting coronary disease. An exception may be made and coronary arteriography not done if the disease is so well controlled medically that its course is one of improvement and the patient and the doctor are so

content with the way things are going that they do not want to take any additional risks. This circumstance may arise, particularly in older individuals, and especially in those whose disease has been stable, but not incapacitating, for many years.

Unequivocal angina pectoris in younger individuals, especially if of recent origin, is a clear indication for coronary arteriography. Thus, the severity and position of the lesions in the coronary arteries can be demonstrated, and the urgency of therapy established.

A large group of subjects have chest pain with atypical features which do not permit the physician to be confident that the problem is coronary artery disease. The usual helpful criterion is the association of anginal pain with exertion and its relief by rest. At times this is so indefinite that no clear opinion can be formed and even after repeated interviews, physical examinations, chest roentgenograms, electrocardiograms, and electrocardiographically controlled exercise tolerance tests no opinion is justified.

Some subjects who have vague and indefinite chest pain have enough features about their discomfort which are suggestive of angina that they will be classed generally as anginal pain. In both of these groups coronary artery disease is found sufficiently often that coronary arteriography should be done.

Another group of subjects who need coronary arteriography are those who are found on electrocardiography to have changes which are suggestive of coronary artery disease. Certainly if the suggestive electrocardiographic changes are confirmed by an exercise tolerance test, coronary arteriography is highly desirable.

If there is any doubt, arteriography is essential before measures are undertaken to alter seriously a patient's pattern of living or his occupation. It is a great disservice to a patient to have his activity severely restricted, to change his occupation, or sell a farm or family business because of atypical pain and electrocardiographic T-wave changes, only to find at a later date that his coronary arteries are normal. It may be difficult or impossible then to turn back the clock on the psychological and financial damage which has been done by several years of enforced disability because of a mistaken diagnosis. In summary, no subject should seriously restrict his life because of the diagnosis of angina pectoris unless the diagnosis is unequivocal; this frequently requires coronary arteriography.

Contraindications

There are relatively few contraindications to coronary arteriography. There seems no pressing reason to do the procedure, and some reason to avoid it in patients with a recent myocardial infarction. This may change if resection of the infarcted myocardium becomes practical, or if acute dissolution of blocks in the coronary arteries becomes feasible. If a patient has another disease such as malignancy which makes coronary artery disease of secondary importance, there is seldom a reason to do coronary arteriography. It is avoided if possible in the presence of infection, decompensation which precludes the recumbent position, and such progressive angina that infarction seems imminent. The latter is a relative contraindication, but if the procedure is done it must be understood that the risk of the infarction is great and that there will be no reasonable way to know whether the infarct occurred spontaneously or was produced by the procedure.

Risks

Since coronary artery disease is so common, a case could be made for doing coronary arteriograms on essentially all subjects in the coronary age group for very minor indications indeed. There are two reasons why this is not desirable. First, treatment of coronary artery disease is such, at present, that it does not justify such a radical search for asymptomatic subjects who have coronary artery disease. Second, there are definite risks in coronary arteriography. These risks may be discussed under four headings: those of arrhythmia, trauma, infarction, and death.

Arrhythmias. Minor arrhythmias are common during the course of coronary arteriography since the cardiac catheter frequently slides across the aortic valve into the outflow tract of the left ventricle and produces ventricular premature contractions. In general these are limited in extent and disappear as soon as the catheter is withdrawn into the aortic root, but they may be more persistent.

Arrhythmias may also arise as contrast material courses through the myocardium, and especially through the pacemakers. The pacemakers are generally supplied by the right coronary artery, and arrhythmias are roughly twice as common during injection of contrast substance into the right coronary artery as they are during injection into the left coronary artery. Commonly, as the pacemaker is perfused by contrast material there is gradual cardiac slowing, through extreme bradycardia, ending in asystole.

It is difficult to define how long cardiac activity must cease before it is called cardiac arrest. When it occurs the patient is urged to cough. This results in effective massage of the heart, through compression, from increased intrathoracic pressure, and ordinarily produces resumption of cardiac activity. On some occasions a prolonged series of coughs is required, and cineangiocardiograms reveal cardiac compression with each cough. Pressure rises in the aorta and peripheral arteries during each cough and contrast material washes out of the myocardium. If the heart does not beat subsequent to coughing, closed chest massage is started, usually with prompt resumption of cardiac activity.

In the cooperative study of cardiac catheterization[1] one death occurred from asystole in 3,312 coronary arteriograms. However, this did not occur during the coronary arteriograms but after the procedure had been finished in a patient with aortic stenosis and regurgitation, hypertension, total occlusion of the anterior descending coronary artery, and an old myocardial infarction.

Ventricular tachycardia may occur subsequent to injection of contrast material or entry of the catheter into the ventricle and may require treatment; however, it usually subsides spontaneously or terminates as ventricular fibrillation. When ventricular fibrillation occurs, prompt through-chest cardiac massage is done. This sustains blood flow and sometimes corrects the arrhythmia. If it is required, through-chest electrical defibrillation of the heart is accomplished. In the cooperative catheterization study there were no deaths from 25 episodes of ventricular fibrillation during coronary arteriography.

Trauma. Trauma may occur at multiple sites during coronary arteriography. The most common site is in the arteries which are used for introducing the catheter for the procedure. Since these subjects frequently have diffuse atherosclerosis in the aorta and the peripheral arteries as well as the coronary vessels, a catheter may become caught beneath an atherosclerotic plaque and penetrate the arterial wall. Perforation may cause considerable hemorrhage. Thrombosis may occur at the site of entry of the catheter, or on an atheromatous ulcer. Infection may occur in any surgical procedure, but is particularly prone to occur when a catheter or similar object is manipulated in and out of an incision over a prolonged period of time, as may occur during difficult catheterization procedures. When the Sones technique is used, the vessel most commonly damaged is the brachial artery. Some prefer to use the femoral artery, and then it becomes the most common site of damage. The subclavian artery, the aorta, or the coronary arteries themselves may be damaged.

Aortic damage or dissection occurs most commonly when a catheter does not enter the ascending aorta cleanly, after passing down a tortuous subclavian or innominate artery. In attempting to manipulate the catheter from the junction of the brachiocephalic vessels into the ascending aorta, plaques in the aortic arch may be lifted up, and the intima may be perforated or torn. During the course of manipulating the catheter into the ostia of the coronary arteries, the region about the coronary arteries is repeatedly probed by the catheter tip seeking the coronary orifice and this may damage the aorta. Furthermore, bursts of contrast material are injected into the sinus of Valsalva in order to see the point of origin of the coronary artery from the aorta. Hence, contrast material may be introduced into the wall of the aorta beneath atheromatous plaques. Indeed, plaques may be broken off and result in an embolus to the brain, the coronaries, or elsewhere.

Either coronary artery may be so stenotic near its orifice that when the catheter is introduced it produces occlusion of the vessel. Since pressure is monitored continuously from the tip of the catheter, this should be immediately apparent. If the catheter is quickly withdrawn, a metabolic deficit does not occur in the myocardium but constant vigilance is required. Dissection of the coronary arteries may also occur and death may result subsequent to its occurrence with occlusion of the vessel lumen. Embolism of the coronary arteries may occur from small bits of thrombus or fibrin formed at the tip of the catheter, from inadvertent injections of bubbles of air, or from material dislodged from the aorta or from the aortic valve during the course of manipulating the catheter.

When in the course of producing optimal opacification, a catheter is introduced too far into the coronary artery, spasm may be induced with very tight constriction of the coronary artery. This ordinarily responds to the administration of nitroglycerin. It is important to recognize that spasm can occur and to relieve it by administration of vasoactive drugs rather than to misconstrue it as organic disease of the coronary vessels.

During the course of curling the catheter repeatedly in the sinus of Valsalva when cannulating the coronary arteries, damage may be done to the aortic valve and aortic insufficiency may result. Damage may be done to the heart also, with the repeated penetration of the catheter through the aortic value into the left ventricle, and perforation of the heart may occur. Perforation is most apt

to be produced when ventriculography is done as part of the catheterization.

Myocardial Infarction. Myocardial infarction may arise from several causes during or near the same time as coronary arteriography. There is always considerable risk that subjects with coronary artery disease will develop myocardial infarction, and this natural course of the disease cannot be distinguished from the effects of a coincident procedure. Infarction may occur during an electrocardiogram, or a coronary arteriogram or almost any procedure which is done on a subject who has angina pectoris. It is clearly more apt to happen during coronary arteriography.

Several specific ways infarction may be produced have already been discussed and may be listed as follows: (1) obstruction of a tight constriction of a coronary artery by the catheter tip, (2) dissection of the coronary artery, (3) injection of bits of fibrin or thrombus formed at the end of the catheter, and (4) arrhythmia and hypotension induced by the procedure.

Death. The ultimate complication of coronary arteriography is death of the subject. The best statistics at the present time indicate that death occurs in roughly one per 1,000 coronary arteriographic studies. The majority of these deaths have occurred from myocardial infarction, several of which seem clearly to have been precipitated by the procedure and some of which were probably not related to it.

It is agreed that death should not be an acceptable complication of a diagnostic procedure; however, a large, recent, prospective survey[1] has indicated that in 12,367 consecutive cardiac catheterizations, death occurred in 0.44%. Thus, death occurs 4.5 times as frequently during diagnostic cardiac catheterization as it does during coronary arteriography. This may give a scale for some perspective in comparison.

Benefits Derived

The benefits which may be derived from coronary arteriography are many. It is a great tragedy to make the diagnosis of coronary artery disease erroneously, and on many occasions coronary arteriograms establish a dubious clinical diagnosis as wrong. Sometimes the diagnosis is wrong even when it seems clearcut. An associated problem is that the continued search for the correct diagnosis is frequently stopped when an erroneous diagnosis of angina pectoris is made. In some subjects no cause for chest pain can be found, yet reassurance that coronary artery disease is not present is adequate to reestablish their equanimity and return them to productive work. Other subjects have skeletal muscle spasm, thoracoabdominal arthritis, fibrositis, esophagitis or spasm; or a large number of relatively benign conditions with which they can live quite comfortably after they have been assured the risk of sudden death from coronary artery disease no longer hangs over their head.

Frequently, after months and years of indecision, patients seem relieved to know that they definitely have coronary artery disease, and that their chest pain is undoubtedly due to it. Under these circumstances it is easier to get cooperation in treatment and modification of daily living habits. An additional benefit which may be derived from clear establishment of the diagnosis of coronary artery disease and clarification of the position of the anatomic lesions, is that some subjects are amenable to cardiac surgery.

Surgery

For many years the Vineberg procedure[2] of implanting the internal mammary artery into the myocardium was widely disregarded since very few believed that it was possible for the implant to carry new blood to the myocardium. When Sones demonstrated that contrast material injected into the implanted internal mammary artery was carried through the myocardial capillary bed and appeared in the coronary sinus, the first objective clinical evidence of myocardial revascularization was at hand. This study has now been repeated and confirmed in many other laboratories.

Furthermore, sometimes sections of the coronary arteries fill with contrast material which has been injected into the internal mammary artery implant. Comparison of the preoperative and postoperative coronary arteriograms reveals that some of the sections of the coronary arteries that are perfused from the implanted internal mammary artery were previously perfused poorly or not at all. Although early implants took chiefly the main trunk, more recently the internal mammary artery implant has been extended by taking all of the distal portion of the artery as well as its side branches and terminal epigastric branches. This permits more extensive revascularization.

It is strongly believed that cigarette smoking is contraindicated in all subjects with angina pectoris but in order to prevent clotting of the arterial graft it is strictly forbidden in those who have "Vineberg procedures." Cardiac arrhythmia is not regarded as a contraindication to the Vineberg procedure. Coronary arteriograms are essential preoperatively since the region and the severity of vascular obstruction must be established before it is known where the implant should be made. It is widely believed that there must be near 90%

occlusion of a coronary artery to ensure adequate ischemia to promote growth of the arterial implant.

The presence of extensive collateral circulation is not felt to contraindicate internal mammary implant since it is considered to indicate continuing severe ischemia. It cannot be emphasized too strongly that the procedure must be tailored to the patient's needs as determined by coronary arteriography, and that the degree of ischemia is the determinant of how readily the coronary vascular bed accepts the new implant.

There is little to be gained by implanting the vessel into an avascular scar, a ventricular aneurysm, or a section of muscle already well supplied with blood. This information should be supplied by preoperative catheterization and rechecked by direct vision at the time of surgery.

In recent years, several institutions have begun the so-called "double Vineberg procedure" in which both internal mammary arteries are implanted into the myocardium. This procedure is done chiefly when lesions are present in arteries supplying both the anterior and posterior surfaces of the heart and the ischemia extends so widely that one additional blood supply is not thought to be adequate. It permits the left internal mammary artery to be implanted on the posterior surface of the left ventricle and the right to be implanted anteriorly. Furthermore it gives additional insurance lest one of the implants becomes clotted. Indeed it has been suggested recently that epigastric arteries be used as well, thus producing a "3 vessel implant."

The mortality for single vessel implantation is approximately 5%. It is higher when more vessels are implanted, perhaps because of the additional surgery but more likely because these procedures have been done in those who have more extensive coronary artery disease. In the early postoperative phase, revascularization procedures are difficult to evaluate because the subjects are inactive, and because they may have chest pain from the surgical procedure which is difficult to differentiate from angina. As the trauma from surgery subsides and as the chest wall recovers its stability and freedom of pain, many subjects are found to be free of anginal pain; and over the first three to six months they show sustained improvement. Clinical results have indicated subjective improvement in about 80% of patients. Figures are not yet available as to whether this procedure increases longevity, although some believe that it does. Long-term studies are underway to see whether any statistical support for this impression can be gained.

Uncommonly, coronary arteriography establishes the presence of a localized lesion in a large enough artery that it is feasible to attack it surgically[3] utilizing cardiopulmonary bypass with coronary perfusion. This surgery might be in the form of an endarterectomy but is more likely to be an enlargement of the lumen of the segment with a vein patch graft, or replacement, or bypass of the segment with a length of saphenous or other vein. The "revascularization" and improvement from such a procedure is immediate and should prevent a threatening myocardial infarction. It is much more applicable to the right coronary artery than to the left. The mortality from such surgery is considerably less than 10% for the right coronary artery but is three or four times that great for the left coronary artery. This is a benefit which is not to be expected from coronary arteriography since it happens uncommonly. Occasionally, however, results are dramatic. □

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NEW PUBLICATION ON EMPHYSEMA

Recent research into the causes and progressive nature of emphysema and other chronic lung diseases is the subject of a new 400-page publication just released by the National Center for Chronic Disease Control, Public Health Service.

"Current Research in Chronic Airways Obstruction" (Public Health Service Publication No. 1717) contains 30 papers presented at the 9th Aspen Emphysema Conference, held in Aspen, Colorado, June 9 to 12, 1966.

Beginning in 1958, a group of 100 national and international experts in chest medicine, physiology, biochemistry, and other medical specialties have assembled in Aspen each June to discuss research projects in chronic lung disease and their clinical experience in caring for patients.

The Chronic Respiratory Diseases Control Program, sponsor of the last three conferences and of the 11th conference held June 12 to 15, this year, is the publisher of the current volume of studies.

A limited number of single copies of "Current Research in Chronic Airways Obstruction" are available from the Public Inquiries Branch of the Public Health Service, Washington, D.C. The publication may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D.C. 20402, for $2.00 each or $150 per hundred. □

Cystadenocarcinoma of the Pancreas

By WILLIAM E. EVANS, M.D., Milwaukee, Wisconsin, and MAJOR RAYMOND G. ARMSTRONG, USAF, MC, Lackland Air Force Base, Texas

■ CYSTADENOCARCINOMA of the pancreas is a rare lesion. In reviewing the world literature Becker, *et al* were able to find only 65 documented cases.[1] Characteristically, this lesion occurs in young adult females, over half of those reviewed being less than 50 years of age at the time of discovery.[2] The chief complaint has usually been that of vague abdominal pain, lacking in specific pattern.[3] A prior history of pancreatitis or abdominal trauma is conspicuously absent. Abdominal examination has disclosed a mass in 85% of cases.[1] Laboratory studies have been of little help. Although cyst fluid may contain pancreatic secretions, serum enzyme studies are usually normal. The most helpful diagnostic aides have been intravenous pyelography and barium contrast with a high percentage showing displacement of kidney, stomach, or colon.

The majority arise from the body or tail of the pancreas, and most present a single lesion, although multiple cystic lesions have been found. Generally, these lesions are quite large by the time they are discovered, only 6 of the patients reviewed by Becker having cysts less than 8 cm in diameter.[1]

These multilocular cystic neoplasms probably arise from pancreatic ductal epithelium as do cystadenomas.[4] Although not a settled issue, current evidence suggests that the malignant form may arise from dedifferentiation of a cystadenoma.[5, 3] Histologic areas of benign cystadenoma adjacent to carcinoma are commonly seen. Cases have also been reported in which many years have elapsed between biopsy of a benign appearing lesion and establishment of a diagnosis of cystadenocarcinoma.[5]

Too few cases have been collected to allow a determination of therapy based on statistical evaluation, although total extirpation of the lesion would appear to be the treatment of choice. Warren, in a review of 10 patients, found that in 6, treated with biopsy, marsupialization or drainage procedures, all died of their disease, whereas in 4 patients, subjected to resection, all survived and were alive 10 to 12 years following surgery.[6]

Fig. 1—Upper gastrointestinal series. Note displacement of the stomach.

Case Report

This patient was a 26-year-old white woman of Spanish descent who was admitted to an Air Force hospital in April 1967 on referral from her base hospital. The patient had been in good health until August 1966, at which time she first noted epigastric and left upper quadrant abdominal pain. The pain was intermittent and cramping in nature. Symptoms subsided after approximately two weeks. During the next several months she noted recurrent bouts of pain of similar location and character. She also stated that she had had a feeling of fullness "as if a knot" were present in her upper abdomen.

Because of the recurrent bouts of abdominal pain the patient was admitted to her base hospital where physical evaluation failed to demonstrate abnormality. An upper gastrointestinal series, however, showed anterior and medial displacement of the stomach, and on the

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Fig. 2A—Large cystic mass arising from the body of the pancreas.

Fig. 2B—The anterior cyst wall has been opened showing the multilocular character of the lesion.

basis of this x-ray study a diagnosis of pancreatic cyst was made and the patient was referred to this hospital. Upon further questioning she recalled that approximately three years prior to admission she had noted a "lump" in the left upper quadrant. There was no history suggestive of pancreatitis or abdominal trauma.

On physical examination a 10-cm, slightly tender, ill-defined mass was palpated in the left upper quadrant. Laboratory data, including evaluation of pancreatic function, were within normal limits. An upper gastrointestinal series showed rather marked anterior and medial displacement of the stomach (Fig 1). Intravenous pyelogram showed no displacement of the kidney or ureter, and no intraabdominal calcification was seen.

A preoperative diagnosis of pancreatic cyst was made and because of the absence of prior pancreatitis or abdominal trauma, neoplastic cyst of the pancreas was considered a good possibility. At exploration a large cystic mass was found arising from the body of the pancreas. The mass displaced the stomach anteriorly and medially and presented inferiorly throughout the transverse mesocolon to which a loop of proximal jejunum was adherent.

The cyst along with the spleen and the body of the pancreas was mobilized to the level of the superior mesenteric vessels. The adherent small bowel was divided proximal and distal to its point of attachment to the cyst and the lesion, and was removed en bloc along with a portion of transverse mesocolon. The remaining pancreas was oversewn and a drain was placed into the lesser sac and brought out the left upper quadrant. An end-to-end, small-bowel anastomosis was done and the rent in the mesocolon repaired.

Postoperatively the patient had minimal drainage from the left upper quadrant stab wound, and drains were removed on the fourth postoperative day; the patient was discharged 11 days after surgery.

Pathology

The smooth walled cyst (Fig 2A) was moderately tense and measured 12 cm in diameter. The outer cyst wall was uniform in thickness and measured 3 mm. At the site of origin of the cyst, the pancreas appeared totally compressed with the cyst wall blending smoothly into the posterior surface of the gland; the tail of the pancreas distal to the lesion was densely fibrotic. There was no serosal involvement of the adherent jejunal segment.

On section the mass was multilocular near its origin from the pancreas with a single, large cyst comprising the anterior half of the lesion (Fig 2B). The cyst contents were thick and mucoid appearing, nonodorous, and yellow-tan in color.

The microscopic pattern was variable. Benign areas contained cysts of varying sizes either lined with cuboidal epithelium or with orderly columnar epithelium (Fig 3A). Interspersed with these areas were foci of Grade I malignant degeneration (Fig 3B). The latter areas contained papillary elements and were characterized by piling up of epithelial elements, loss of basal nuclear polarity, and pleomorphism. Intercystic septa were, for the most part, composed of rather dense collagenous tissue exhibiting chronic inflammatory reaction containing plasma cells. In areas adjacent to malignant cysts, invasion of septa was manifest by nests and cords of malignant cells with a limited tendency toward forming glands. In no section examined was there evidence of invasion of the tumor beyond the confines of the outer capsule wall. The adherent jejunal segment was entirely normal.

Discussion

A most interesting feature of this lesion was the presence of varying, benign cyst linings ranging from flattened cuboidal to tall columnar intestinal-like epithelium with papillary elements. According to Becker *et al,* the former pattern tends to show no malignant potential while the latter is present in lesions undergoing malignant degeneration. The findings of Grade I malignant change are consistent with the majority of observations made by Cullen *et al* in 17 cases reviewed at the Mayo Clinic, although higher grades of malignancy may be encountered.

Although rare, a neoplastic cyst of the pancreas was considered in this patient preoperatively. The presence of a mass in the left upper quadrant, which did not appear to arise from the kidney or spleen and which displaced the stomach, made the diagnosis of a pancreatic cyst a good possibility. No evidence or history of pancreatitis or abdominal trauma could be elicited, and this decreased the likelihood that this mass was a pseudocyst. The findings at operation of a large cystic lesion arising from the pancreas with virtually no inflammatory reaction about it, and the fact that adjacent structures did not make up a part of the cyst wall, gave further support that this was not a pseudocyst or retention cyst.

Although an occasional congenital cyst of this size has been encountered, the likelihood that this was a neoplastic cyst lead to the decision to totally resect the mass. It appears important to make this distinction because treatment oriented to pseudocyst, such as internal drainage, marsupialization or external drainage, is unlikely to result in satisfactory solution to this problem. Neoplastic cysts characteristically have an epithelial lining capable of continual secretion. If marsupialization or external drainage is carried out, the possibility of continuation of the fistula because of active secretion is to be feared, and because of the multilocular structure of these lesions internal drainage does not usually result in adequate decompression. The possibility of a malignant lesion being present or of malignant degeneration of a cysta-

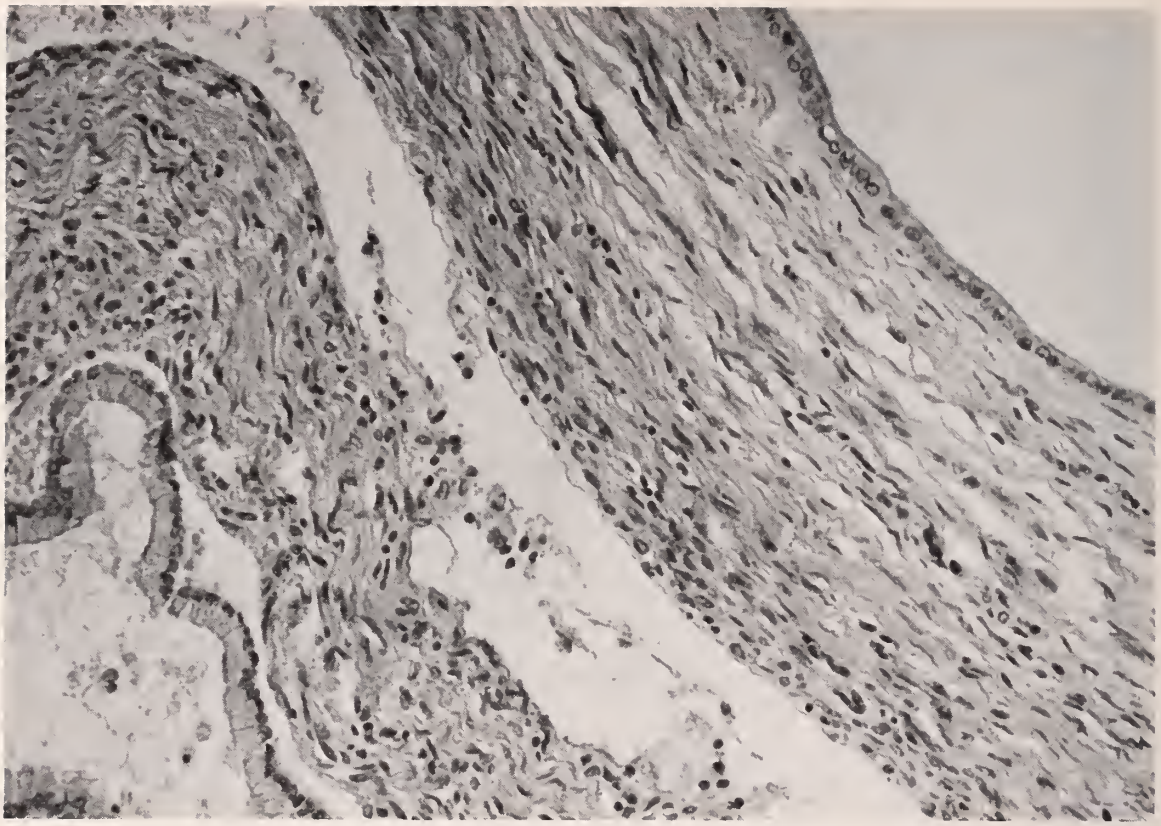

Fig. 3A—Variable microscopic pattern is noted. Both cuboidal and columnar epithelial lined cysts which appear benign are seen.

Fig. 3B—Foci of Grade I malignant degeneration.

denoma is self-evident and certainly points toward total excision as the treatment of choice.

Summary

A case of cystadenocarcinoma of the pancreas is presented, and considerations of pathology, diagnoses, and treatment are discussed. □

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UNUSUAL LOCATIONS AND MANIFESTATIONS OF GLOMUS TUMORS (GLOMANGIOMAS)

DAVID B. APFELBERG, MD and JACK L. TEASLEY, MD, Milwaukee, Wis.: *American Journal of Surgery* 116:62–64 (July) 1968

Glomus tumor is an uncommon soft tissue found in a variety of sites. The surgeon who deals with frequent local excisions should be familiar with this entity since the relatively constant clinical findings should suggest the diagnosis preoperatively to the careful observer. The fact that this lesion occurs subungually and also in a variety of other locations is emphasized and demonstrated by two brief case reports in this review.

Historically, this lesion was first described in 1812 by Wood with the first accurate clinical description of "painful subcutaneous tubercles." Later a typical subungual location was described, and in 1924, Masson described the histology of this tumor.

Typically, glomangiomas are small painful nodules most commonly found in the subungual area of the fingers. Pain is a very common symptom, in some series being present in 100 percent of patients. The pain is usually triggered by pressure or trauma and may present as paroxysms lasting from minutes to hours. The pain may arise spontaneously and usually radiates with the tumor as a focal point.

The tumor itself presents as a bluish red nodule rarely more than 1 cm in diameter. The most common single location is subungual in the hands. This is reported as high as 75 percent by some authors. Other frequent locations are the digits, the forearm, the leg, and the knee. Other authors have also presented cases of glomangioma in unusual locations, such as the patella, the eyelid, the nasal fossa, and the stomach.

Men are affected twice as frequently as females.

Local excision cures symptoms. Recurrences are infrequent. Occasionally, the tumor expands sufficiently to erode bone, hence, preoperative x-ray examination is indicated.

The authors present two patients. The first patient had an extremely tender mass in the right forearm. Pressure on this produced paroxysms of pain down the arm. The preoperative diagnosis was ulnar nerve neuroma. Excision under local anesthesia revealed a reddish-brown granular tumor. The histological diagnosis was glomangioma.

The second patient had a tumor in his index finger which was present for several years, and complained of sharp shooting pain and numbness when the finger was bumped. The lesion was excised under local anesthesia with no recurrence of symptoms. The diagnosis was glomangioma. The typical history of pain on pressure in a subcutaneous lesion in the upper extremity should suggest the diagnosis preoperatively. Several histological types are suggested.

Two cases of glomangioma are presented, neither found in the common subungual location. The clinical characteristics of upper limbs location, paroxysms of pain on pressure, and subcutaneous location of a round firm mass should suggest glomus tumor.

It is hoped that a more frequent and accurate preoperative diagnosis can be made by an increased awareness of clinical features of glomangioma. □

NICKEL EARLOBE DERMATITIS

THOMAS L. WATT, MD, and ROBERT R. BAUMANN, MD, Monroe, Wis.: *Archives of Dermatology* 98:155–158 (Aug) 1968

The recent revival of the fashion of pierced earlobes has resulted in an important and undesirable consequence, nickel sensitization. Often this complication is mistaken for a chronic bacterial infection.

During a 12-month period, the authors observed 17 young women who became allergic to nickel following earlobe piercing procedures. All of the women developed draining, eczematous, pierced earlobes after wearing implanted earrings two to four weeks. Ten of them subsequently developed more widespread eczematous reactions. All of the women were found to have strongly positive closed patch test reactions to 5% nickel sulfate ($NiSO_4$).

Fifteen of the 17 women were found to have definite signs or symptoms of the atopic diathesis. The criteria for the establishment of atopy is discussed. □

From the Department of Dermatology, The Monroe Clinic, Monroe, and the University of Wisconsin, Madison.

Therapeutic Dilemmas

No. 17 of a Series

Editor:

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COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

DIURESIS

Moderator: MAYNARD D. POLAND, MD

Participants: SAMUEL HOKE, MD
ERNEST BURNELL, MD
HERBERT W. POHLE, MD
EDWARD J. LENNON, MD

Dr. Maynard D. Poland: We are reviewing this morning the case of a patient who presented interesting problems in the realms of heart disease, liver disease, diabetes mellitus, and the possibility of carcinomatous implants. However, we shall concentrate exclusively upon this lady's ascites as a point of departure for discussion of the role of the modern diuretic agents in control of edematous states. As principal discussant we are privileged to have with us Dr. Edward Lennon, who as you know is Associate Professor of Medicine at Marquette School of Medicine and Director of its Clinical Research Center at the Milwaukee County General Hospital, where he is also Chief of the Renal Division. Doctor Hoke will present the case.

Dr. Samuel Hoke (Resident in Medicine): The patient, a 70-year-old white woman, recovered in this hospital, during the summer of 1967, from a myocardial infarction. She was discharged taking digitalis and diuretics. At this time there was no manifest kidney or liver disease and she was not accumulating fluid. While in Florida, in December, she noted the beginning of abdominal distention during a bout of gastroenteritis with diarrhea, and the progressive increase in this distention finally forced her return to Milwaukee for medical attention in early February.

Physical findings at the time of this second admission were blood pressure of 124/80 mm Hg; no distention of neck veins; a few scattered râles in the chest; irregular irregularity of the heart; a mid-epigastric, tender mass, which was thought to be a lobe of the liver; no peripheral edema but gross abdominal distention with a fluid wave.

The patient, who had been known to be diabetic for 14 years, had been fairly well controlled on the oral antidiabetics. In 1941, in another city, she had been treated with radium to control excessive menstrual bleeding, apparently with the diagnosis of endometrial hyperplasia. The patient did not smoke or use alcohol.

The laboratory findings on admission Feb. 10, 1968, were hemoglobin 11.7 gm, hematocrit of 35%, CO_2 of 30.5, chlorides of 101, Na of 142, and K of 3.6 mEq/liter. On Mar. 3, 1968, the electrolyte findings were CO_2 of 35, chlorides of 93, Na of 140, and K of 3.2 mEq/liter. Liver function tests on February 28 were essentially normal—bilirubin, 0.2/0.8 mg/100 ml; alkaline phosphates, 6 units; SGOT and thymol turbidity, no elevations—and remained normal throughout the hospitalization.

Paracentesis was performed, withdrawing 3000 ml, which had a protein content of 1.6 mg/100 ml. A cell block for malignant cells was negative. Liver biopsy provided a diagnosis of nutritional cirrhosis. Treatment was with spironolactone (Aldactone) and furosemide (Lasix). She lost 13 lb, from 165 to 152 lb, and was discharged in improved condition.

Dr. Poland: Are there significant x-ray findings?

Dr. Ernest Burnell (Resident in Radiology): None that are really significant. During the admission for infarction last summer, there was simply evidence of massive cardiac enlargement and pulmonary edema. During the recent admission, we have films throughout February and early March, with no great differences among them. I show one here (Fig 1), in which you see predominantly left ventricular enlargement of the heart, with prominence of the pulmonary artery segment and a great plaque of calcium in the aortic knob, with atelectasis at the base evidenced by these linear densities. One item of interest was elevation of the right hemidiaphragm that was present in all the films. When one is obliged to determine whether there is pleural effusion where there is a big heart and apparent elevation of the right hemidiaphragm, the question of infrapulmonic effusion arises—for fluid can collect below the diaphragm and give precisely the appearance of an elevated diaphragm. Under such circumstances it is usually advisable to do a lateral decubitus study to determine whether pleural effusion is actually present.

Dr. Poland: Doctor Pohle, as attending physician on this case, have you anything to add?

Figure 1

Dr. Herbert W. Pohle (Chief of Staff): From the beginning of my experience in this case there has been confusion regarding the cause of the ascites, because at the time of the first radium implant, in another city, there was a difference of opinion as to the nature of the endometrial biopsy specimen. In the city in which the tissue was taken it was considered to be endometrial hyperplasia, but a diagnosis of endometrial carcinoma came back from the state laboratory in Madison. Because the bleeding was postmenopausal, the decision was to use radium and not do a hysterectomy. So when we were confronted with ascites 10 years later, we did not know whether we were dealing with a manifestation of cardiac or hepatic disease or a neoplasm.

We had some difficulty in getting her into the hospital at once on her return from Florida and in the interim managed to effect a 10-lb weight loss with diuretics. The disparity between the amount of the ascites and the evidences of heart failure, and the low specific gravity of the ascitic fluid and absence of tumor cells in it, led us to do the liver biopsy, which provided the unequivocal diagnosis of nutritional cirrhosis. Among the clinical findings tending to confirm this have been morning anorexia, the anemia that has been brought to your attention, and the abdomen full of fluid without any edema of the ankles. The serum proteins and the albumin-globulin ratio have been normal and there has been no proteinuria or anything to suggest diabetic renal disease. I have sometimes wondered whether all the oral antidiabetics this patient has taken might be a factor in the causation of the hepatic disease. Spironolactone (Aldactone) was not effective in reducing the abdominal effusion and furosemide (Lasix) only partially so; best results have been had with ethacrynic acid (Edecrin) orally. The patient is now at home on this drug, still with some palpable ascites.

Dr. Poland: Doctor Lennon, would you like to discuss this subject as a whole now?

Dr. Edward J. Lennon: About the vigorous treatment of ascites in such cases as this, I should like to say at once that I am a pessimist, for my experience has been that if you can't do anything to heal the liver with rest, improved nutrition, and the like, you can only get rid of the ascitic fluid temporarily. These people have a bleb in their balloon, so to speak; their extracellular fluid has a new compartment to enter. There must somehow be a considerable increase in portal pressure in this morning's patient to cause this amount of transudation in the absence of significantly lowered serum protein. Usually in these people there is venous hypertension within the abdomen and lower serum proteins. The ascitic pool accumulates and if you reduce its size you are, ipso facto, reducing the size of the total effective extracellular fluid volume; i.e., you are not only cutting down the abdominal distention but also reducing the amount of those fluids that carry nutrients to body cells and remove waste products from them. I think you are in the best position if you let the patient keep a little fluid in the abdominal cavity or in the peripheral tissues; let him have a little ascites or dependent edema. Of course, if the ascites is excessive and the patient made very uncomfortable, then you'd best get rid of some of it.

This morning I shall review the diuretics and the manner of their actions, since there has been something of an "explosion" in the production of new drugs in recent years as well as in our knowledge of how the kidneys handle sodium physiologically, the latter matter being of paramount importance.

The glomerular filtration rate being of little primary importance in the regulation of Na excretion, I shall confine my remarks to occurrences in the renal tubules almost exclusively. Referring to the diagram (Fig 2), I call your attention to the fact that if a certain amount of Na—say 100 "units"—is being filtered into the collecting system, 70%, or 70 units, of this will be reabsorbed

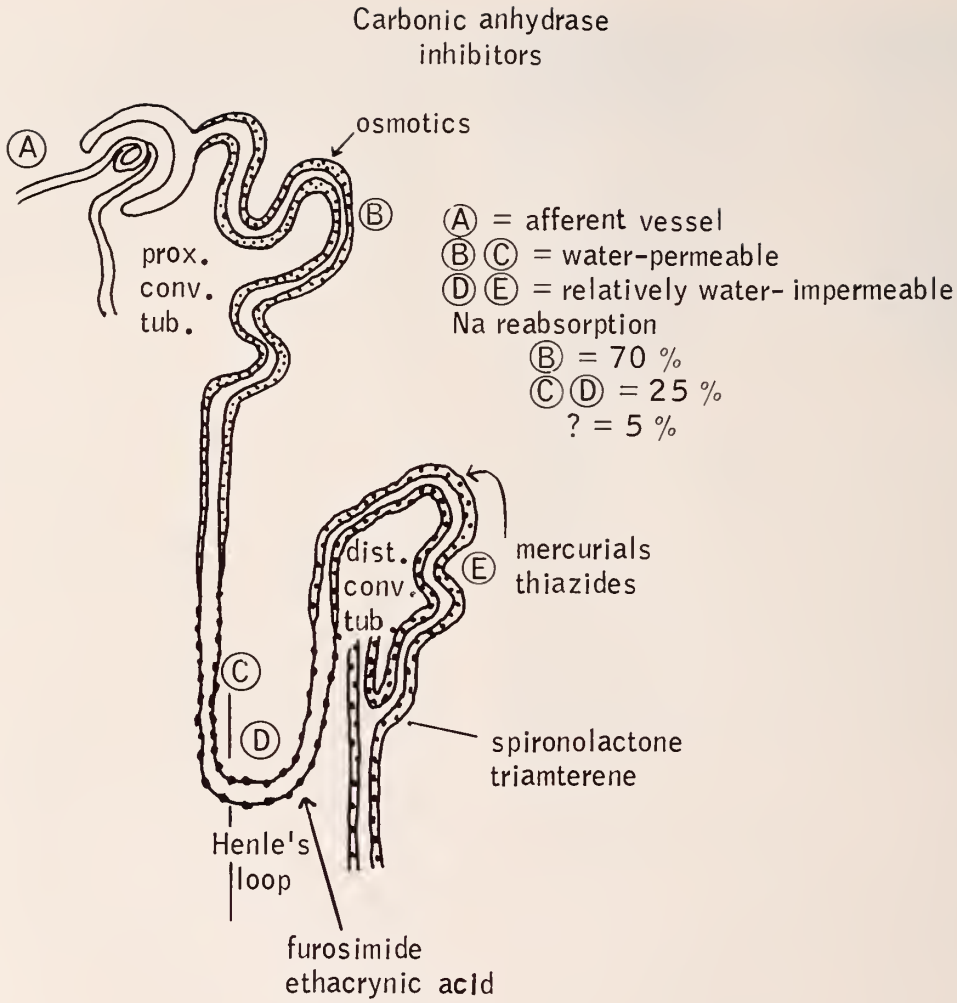

Figure 2

in the proximal convoluted tubule and the remaining 30 units will pass on down into the other segments. Now if the filtration rate is suddenly changed and only 50 units are coming into the system, the proximal convoluted tubule will still take out its 70%, or 35 units, leaving in this case only 15 units to pass on. It is obvious nevertheless that whereas the decrease in the amount that entered the system was 50 units, the decrease in the amount that escaped reabsorption in the proximal tubule was only 15 units. Thus it appears that the kidney has a protective mechanism to buffer against alterations in the Na excretion rate when transient changes occur in the filtration rate. One might call this the "first factor" in the regulation of Na reabsorption by the kidney.

The "second factor" is operative through aldosterone, the specific salt-retaining hormone, which is known to increase Na reabsorption throughout the nephron—in the proximal tubule, in Henle's loop, in the distal convoluted tubule. One of the mechanisms stimulated is that which causes reabsorption of Na in exchange for either an H or a K ion; the patient will therefore excrete increased quantities of K and acid in the urine and become both hypokalemic and alkalotic. The renin-angiotensin system operates to stimulate aldosterone production through a feed-back mechanism responsive to the relative "fullness of the circulation." When the pressure within the smaller arteries is decreased, there is decreased stretch in the afferent arterioles of the glomerulus. Within these arterioles there is a group of granulated cells, the juxtaglomerular apparatus, which contain the hormone renin. Renin is released into the circulation in response to decreased stretch in the arterioles and converted into angiotensin through a circulating protein produced by the liver. Angiotensin, in addition to its pressor action, also specifically stimulates the adrenals to secrete aldosterone.

Clearly, there is a "third factor" of importance in Na regulation, although the evidence regarding it is not yet entirely clear-cut. It appears that expansion of the circulation brings about the production within the hypothalamus of a hormone which acts specifically to inhibit sodium reabsorption in the proximal convoluted tubule. Studies of this mechanism are under way in numerous laboratories and are being closely watched.

If you will now look at Figure 2 again, you will see that I have drawn a line at about the mid-point of Henle's loop. This is not a casual division, because one may actually say that all segments of the nephron on the left of this line—the proximal convoluted tubule, the descending limb of Henle's loop—are water permeable. On the other hand, the segments on the right—the thin ascending limb, the thick ascending limb, the distal convoluted tubule, the collecting ducts—are relatively impermeable to water. Thus when Na is reabsorbed in the left-side segments, water is also reabsorbed in isosmotic quantities—so that the fluid exits from this area in a form isosmotic to plasma. However, as it issues from the ascending limb in the right-side segment it is hypotonic because Na but not water is reabsorbed here. And it becomes even more hypotonic for the same reason as it passes through the distal convolution.

Clearly, from the above, the site of action of a diuretic drug will determine the nature of its action, and therefore drugs acting at the *same* site can be expected to produce diuresis through effects upon similar mechanisms. If, however, we use a combination of drugs acting at *different* sites we can expect an augmentation of urine production through more than one mechanism. It does not greatly matter that time limitations forbid an exposition of the intricate pharmacologic actions of our drugs this morning, for merely knowing where they act is sufficient for clinical purposes. From Figure 2 again, you will see that to inhibit proximal sodium absorption we have two groups of agents: such carbonic anhydrase inhibitors as acetazolamide (Diamox), and such osmotics as mannitol and low-molecular weight dextran (Plavolex, and the like). To inhibit the capacity to effect maximal dilution of the urine, we have the mercurials (Mercuhydrin, and the like) and the thiazides (Diuril, and the like), operating in the upper part of the distal convoluting tubule. To inhibit Na reabsorption at the K-H exchange site, we have the aldosterone antagonist spironolactone (Aldactone-A), and triamterene (Dyrenium), which inhibits the reabsorption of Na at the exchange site even in the absence of aldosterone. Then to inhibit the capacity of the kidney both to concentrate and to dilute the urine, we have the newest agents, furosemide (Lasix) and ethacrynic acid (Edecrin), acting in the thin ascending limb of Henle's loop.

Now in a situation in which the patient's excessive fluid retention makes you think of going to a *combination* of diuretics, how should you proceed? Obviously, giving ethacrynic acid plus furosemide would simply be equivalent to giving more ethacrynic acid since both drugs act at the same site. If, however, you use a combination of ethacrynic acid and mannitol, which act at different sites, you can expect considerable potentiation of action; in fact, you can deliver something like 20% of the glomerular filtrate as urine with this combination. This can be a nerve-racking experience that might require you to deliver intravenous infusion at three or four ports to keep up with the patient's outpouring of urine! Potentiation might be expected also through combination of a thiazide with ethacrynic acid or furosemide, for here again there is action at different sites.

The use of furosemide, ethacrynic acid, the thiazides or mercurials can get you in trouble through K losses, as was demonstrated in our patient today. If you give ethacrynic acid, for example, and inhibit Na reabsorption in the thin ascending limb of Henle's loop, more Na will be delivered to the distal segment. But this will augment aldosterone production, more Na will be taken back, and K and H will be lost in the process. So then triamterene might be used in combination to block this.

For my part, I think that mercury still remains an extraordinarily effective diuretic for intramuscular use in the hospital, and that the major impact of these newer drugs is to present the possibility of prolonged oral therapy outside the hospital. Furosemide and ethacrynic acid should be handled with considerable respect for their trouble-making possibilities as well as their diuretic potential. When ethacrynic acid was under study before its release, we gave a perfectly normal, nonedematous individual a couple of doses of it during one day—and he lost 2.5 kilograms (5½ lb) over night and was quite dizzy next morning! My advice is to treat these new agents with the same caution that you employ in using the mercurials. Rarely should they be used on a daily basis; give them a couple of days a week, with supervision.

A Physician: Can K conservation actually be demonstrated through such a combination as you last mentioned—furosemide or ethacrynic acid together with triamterene?

Dr. Lennon: Yes, indeed—but I hesitate to mention it because some pharmaceutical company

will be sure to put out a combined pill, which will of course completely hobble the chance of manipulating dosages.

A Physician: Where does antidiuretic hormone (ADH) enter into this picture?

Dr. Lennon: The fundamental action of ADH is to alter the properties of the cellular membranes within the collecting ducts. Referring to Figure 2, you will recall that all structure to the right of the dividing line tends to be water impermeable. When there is the necessity to conserve water and excrete a concentrated urine, ADH is liberated and acts to make this right-side segment more permeable to water. It also may have effects on medullary blood flow; and since the medulla is always hypertonic, all one has to do is make this right-side segment more water-permeable and water will diffuse out of the collecting ducts and into the medulla, and thus not be lost in the urine.

A Physician: How would you explain the curious effects of diuretics in diabetes insipidus?

Dr. Lennon: You will note that the effective ones (most experience has been had with the thiazides) act in that segment where the urine is made more dilute. Thus, through inhibiting sodium reabsorption at that site, you tend to achieve an isosmotic urine rather than the very dilute one typical of diabetes insipidus.

A Physician: Doctor Pohle raised the question of the effect of the oral antidiabetics on the liver. Would Doctor Lennon care to discuss this?

Dr. Lennon: When I went to Boston after service at the county general hospital here in which we had given oral antidiabetics to many hundreds of patients without dire effects, I was given to understand that I was asking for trouble in prescribing these drugs since they were horrible hepatotoxics. But I have not had evidence of this; we have seen mild disturbances in liver function only very rarely. However, I am nervous about life-long therapy with any agents and therefore feel it conceivable that some liver damage may ultimately be shown. Presently I have simply not seen it.

A Physician: I have had two patients with proven diabetes insipidus, one here in the hospital, in whom chlorpropamide (Diabinese) unquestionably inhibited water loss. Tolbutamide (Orinase) had some effect also, but acetohexamide (Dymelor) and tolazamide (Tolinase) were completely ineffective. It was interesting also that the ineffective agents caused the patients to become hypoglycemic, but the effective ones did not.

Dr. Lennon: Did you have a chance to test whether these agents inhibit urinary dilution in normal subjects?

The Physician: No, I did not.

A Physician: Is diuresis usually accompanied by a compensatory increase in aldosterone production?

Dr. Lennon: Yes, that is true. The kidney plays tricks on us all the time. It is well established that if you inhibit Na reabsorption in distal segments, the proximal segments increase their Na reabsorption; and if you inhibit proximal Na reabsorption, distal reabsorption increases. Mechanisms at interplay within the nephron fight almost anything we do.

Dr. Pohle: Is there any evidence that with prolonged increase in intravascular volume an abnormal steady state might be reached in which the kidney would "settle for" this amount of stretch and not alter the outflow?

Dr. Lennon: I think that this could be an important factor in some of the fluid-retaining states with which we deal. For example, there is evidence in heart failure of a low plasma level of what has been called "third factor." Perhaps we shall sometime have means of altering this third factor artificially at will.

A Physician: In addition to their effects on Na and K excretion, the diuretic agents elevate the blood uric acid titer and lower the urinary uric acid excretion. Do they cause a rise in blood urea nitrogen (BUN)?

Dr. Lennon: There is not an elevation in BUN unless blood volume depletion occurs. I have seen people get into serious trouble in this way when a much greater diuresis was achieved than had been expected. In such a situation you must get some of the salt back into the patient.

Dr. Poland: Do not individuals with diabetic nephropathy sometimes experience a rise in BUN under thiazides because of their markedly compromised glomerular filtration rate?

Dr. Lennon: In most patients who have a physiologic reason for their edema or ascites you cannot rid them of the retained fluid without compromising their extracellular fluid volume, ergo the rate of delivery of everything to the kidney. To repeat, with volume depletion a rise in blood creatinine and urea nitrogen can be anticipated.

A Physician: In repleting the K loss indicated by thiazides and like agents, is it important to replace chloride specifically? There seems to be a difference of opinion whether one should use potassium gluconate or chloride in such a patient.

Dr. Lennon: Dr. William Schwartz's work (*Amer J. Med.* 38:172, 1965) during recent years has clearly shown the importance of replacing chloride, since it is impossible to achieve a bicarbonate diuresis unless you have chloride in the

diet. The K-depleted patient is usually also alkalotic because of the distal Na/K and H exchange mechanism of which I have already spoken. The kidney is caught in a trap. It must take Na back, but in doing so it pairs the Na more than normally with bicarbonate and thus the alkalosis is perpetuated. Given the option of choosing between a chloride and a bicarbonate ion it will preferentially take the chloride, but this ion must be provided. Giving chloride to the individual will permit a bicarbonate diuresis.

Dr. Poland: I recall being told during my training that you could not get a diuresis with the agents then available unless you had a serum chloride of 95 to 100 mEq/liter. With a serum chloride below this would you prime the pump with ammonium chloride?

Dr. Lennon: The mercurials will not work if the medium is not acid so that mercury can dissociate from the organic complex. So if the patient is alkalotic, these agents are ineffective. So you must overcome the alkalosis. The thiazides can perhaps be inhibited in their action to some extent by alkalosis, but the other modern agents do not really create this problem for us.

A Physician: I have heard of an instance in which ethacrynic acid was used in an attempt to maintain urinary output in surgical shock, much as one might use mannitol. Would Doctor Lennon comment on this?

Dr. Lennon: I disapprove of measures designed primarily to increase urine flow in situations, such as the type of shock you specified, in which the trouble stems from volume depletion. The first need here is for repletion with blood or plasma or saline. If you supply these, the patient will make urine; if you do not, you may lose him. Conceivably your attempts to force urine production through other measures may reduce the incidence of acute tubular necrosis later, but what good is that to a dead man?

A Physician: I have seen three or four individuals who complain of moderate backache an hour or two after taking a thiazide and a severe backache after taking furosemide or ethacrynic acid. Has this been common experience?

Dr. Lennon: I have not seen it nor any account of it. However, a situation in which I could imagine this happening would be in a person with a low-grade ureteropelvic junction obstruction, who, when required suddenly to excrete an unusually large amount of urine, might develop an acute hydronephrosis. An intravenous pyelogram might show something in such a case.

A Physician: The sort of metabolic acidosis of which you have spoken decreases cerebral blood flow, which probably accounts for the convulsions. Does it decrease renal blood flow also?

Dr. Lennon: I am not aware of any determinations that would enable me to answer that question, although they probably have been made.

Dr. Poland: Doctor Lennon, would you care to comment on the matter of reinfusion of ascitic fluid?

Dr. Lennon: The concept is of course that ascitic fluid is somehow more physiologic than other kinds of fluid and that in reinfusing it you are not stealing additional albumin from the patient. I disapprove. If I want to put albumin back, I prefer sterile salt-poor human albumin to the nice bacterial broth that ascitic fluid is.

Dr. Poland: Might we ask for your opinion of the hepatorenal syndrome?

Dr. Lennon: I am not sure that this syndrome exists, and I believe that it is a dangerous diagnosis to make. The term has been used indiscriminately in individuals whose liver disease is complicated by acute glomerulonephritis, acute tubular necrosis, or toxic nephropathy. In times past, pathologists used to talk about "cholemic nephropathy," which meant that the kidney was bile-stained like all the other body tissues—and I don't know that that is so bad for it. No one dealing with a large number of cirrhotic cases has any doubt that one of the terminal events is a fall in urinary output, which often precedes overt evidence of shock. I do not recall ever having seen a patient survive this unless the renal failure was superimposed and of a sort that something could be done about it with direct measures. I am unaware of any satisfactory explanation of the kidney failure in cirrhosis, but it is one of the signs of impending death.

Dr. Poland: Thank you, Doctor Lennon. (Summarizing) This morning we have had a comprehensive presentation of the subject of diuresis and have ranged widely into many of the therapeutic problems posed by fluid retention in edematous and cirrhotic states. □

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Medical Therapy of Epilepsy

By PHILIP T. WHITE, M.D., Milwaukee, Wisconsin

■ As a preface to any discussion of the medical therapy of epilepsy, the probable symptomatic nature of all types of seizures must be stressed. Idiopathic epilepsy is a diagnosis that should be made only after careful study.

The first obligation of the practicing physician is to find a cause for seizures and to correct or remove this cause when possible. In the event that it is impossible to discover or remedy a cause then one may resort to symptomatic therapy using anticonvulsants. It may be quite proper to use this symptomatic therapy during the course of the investigation as long as it is recognized that these medications may control seizures even in the presence of underlying progressive disease, and, therefore, mask the seriousness of the underlying cause.

The following statements are based on the assumption that the principles of medical therapy will be applied at the same time that due regard is given or has been given to the possible underlying causes for seizure.

The perfect drug would be that which the patient could take once and forever after remain seizure-free. The ideal drug for the control of seizures has yet to be discovered. While some of the modern preparations are highly effective, a panacea is not available. Thus, the search goes on as it has for centuries. A statement has been made, "There is not a substance in the materia medica, there is scarcely a substance in the world, capable of passing through the gullet of man, that has not at one time or another enjoyed a reputation of being an anti-epileptic."[1]

The more modern attempts to control seizures by the use of drugs dates from the middle of the last century. In 1857, Locock[2] discussed the use of bromides in hystereoepilepsy. Others using this as a clue began using bromides in nonhysterical epileptics, and by 1861 Wilks[3] reported that it was an effective form of therapy.

In 1912, Alfred Hauptmann[4] first reported on the efficacy of phenobarbital (Luminal) in the control of seizures. Today, phenobarbital is probably the medicine most frequently used, and, in addition, has served as a model for the development of other successful anticonvulsants. The basic barbituric acid radical with various additions and alterations has produced most of the drugs that we use in the control of seizures. Exceptions would be the bromides, acetazolamide (Diamox), and quinacrine hydrochloride (Atabrine).

In 1938, H. Houston Merrit[5] and Tracy Putnam reported the results of the use of diphenylhydantoin (Dilantin). The popular acceptance of this drug rivals that of phenobarbital and, in turn, has served as a model for the development of further hydantoins.

Trimethadione (Tridione), in 1944, proved of value in the control of seizures in small animals, and subsequent studies revealed its efficacy in the control of petit mal epilepsy.[6, 7] Until recently, trimethadione was the most effective preparation for the control of so-called petit mal, but is now being supplanted by ethosuximide (Zarontin).[8, 9]

In more recent years, a multitude of other drugs has been developed and advocated for the control of seizures. Many of these are simply variants of the barbituric acid or hydantoin formulas, and with the possible exceptions of primidone (Mysoline) and ethosuximide have failed to demonstrate superiority or even equality when possible merits are weighed against toxic side effects. Nevertheless, when the more commonly used drugs fail after an adequate therapeutic trial, others may be successful and should be tried. However, the success of

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any drug depends upon its appropriate and adequate utilization.

Drugs, alone, are not the answer to the whole problem of epilepsy. Many other factors, such as emotional ones and social, educational, and economic factors have to be considered. These factors may influence the types and amounts of drugs used and bear upon the success of therapy.

The first step in achieving adequate drug therapy is to establish the types of seizure the patient is having. One has to distinguish between two large groups of seizures: petit mal or absence on the one hand, and all other forms on the other. With such blanket statements there are exceptions, but in general the types of drugs used for the control of petit mal epilepsy will differ from those used for the control of all other forms of epilepsy or seizures. If used inappropriately, the drugs not only may be ineffective but also may aggravate seizure frequency. Further, in patients who have petit mal in combination with other seizure forms, it may be necessary to use different types of drugs simultaneously.

Not all seizures that are small are petit mal. Petit mal or absence attacks occur more commonly in childhood and rarely, if ever, have their onset after late teen-age. The term "absence" is being applied to these seizures now, for indeed the individual attacks are generally a simple absence or brief interruption of responsiveness, awareness, and consciousness. Characteristically, the individual seizure lasts only a few seconds, is nonconvulsive in nature, and any associated manifestations tend to be simple and primitive, such as licking of the lips, chewing, mild blinking about the eyes, or purposeless fumbling. In addition to brevity, they are characterized by frequent occurrence, and in the untreated patient 50 or more attacks per day is not uncommon. This combination of age of onset, brief duration, rudimentary manifestations, and frequent occurrence is usually sufficient evidence for an appropriate diagnosis. Although not specific, certain patterns in the electroencephalogram help distinguish petit mal from other minor seizure types.

After the judgment as to the seizure type has been made, other principles apply. These include the following considerations: (1) The safer drugs should be tried first. (2) Drug therapy should be continuous, and the casual use of anticonvulsants not only is of no value but also may contribute to the occurrence of status epilepticus. (3) Treatment should be aimed at achieving improvement or control of attacks with as few side effects as possible.

It is conceivable that all patients with seizures could be completely controlled, but many only at the expense of being totally obtunded. Therefore, the appropriate judgment at times may be that a small number of persistent seizures is preferable to further increases in medication and consequent side effects. This would be particularly true of the minor forms of seizures or petit mal where the persistence of a few daily attacks may not seriously interfere with the person's adaptation to his environment and the addition of further drugs cannot be readily justified. The aim of therapy is to achieve an optimal functional state, not just to control seizures.

With these principles in mind, an appropriate drug is prescribed in reasonable amounts. Reasonable amounts may vary according to the age and size of the patient. If the initial dose is inadequate, it is systematically increased until either seizures are controlled or toxic side effects are encountered. The frequency with which increases are made will depend to some extent upon the frequency of the seizures in the individual patient. In patients with seizures occurring only a few times a month, one may have to wait a few weeks before judging whether more medication is needed. Even in patients with many seizures a day, judgment that the dosage is inadequate should not be made prematurely because there may be a delay in the achievement of therapeutic blood levels with certain preparations, notably diphenylhydantoin.

If control is achieved with nontoxic quantities of drugs, no further steps are necessary. If toxic effects are produced prior to adequate control, the initial drug should be reduced to the last previously tolerated dosage and a reasonable amount of a second drug is added. The second drug is then systematically increased until control or toxicity is reached. In some cases, the same procedure will have to be followed with a third or perhaps even a fourth drug. Even after control is achieved, the clinician must keep in mind that side effects may subsequently appear as is true of many drugs used for long periods of time.

The importance of regularity of medication must be stressed to the patient. Even a single missed dose at wide intervals may prevent the achievement of control. It is important that the patient be helped to develop proper habits for taking medication. One helpful mechanism is to instruct the patient to put all drugs to be used during the day into a small bottle. At any time during the day the patient can look at the bottle, see whether drugs have been taken according to schedule, and if not, take at that time.

The patient's willingness to take drugs and the habits of doing so will be enhanced by following a simple, easy schedule. One or two relatively

large doses of medication per day may be as effective as multiple small doses. This is known to be true of diphenylhydantoin of which it has been shown that a single 300 mg-dose is as effective as 100 mg three times a day in the maintenance of effective therapeutic blood levels. Phenobarbital may have some of these same virtues, as only a small percentage of the compound is eliminated in the first 12 hours. However, it may be desirable to avoid the sedative effect of phenobarbital by giving smaller amounts more frequently.

The fate of some of the other anticonvulsants is not clearly understood, but presumably other barbituric acid derivatives and other hydantoins might have this same advantage. In any event, it is rarely, if ever, necessary to prescribe multiple doses of drugs throughout the day and night. It is improbable that a scattering of drugs is effective. It is highly probable that it will disillusion the patient and impair his cooperation. In some large institutions for the care of epileptic patients, it now is common for a single large dose of combined medications to be given at bedtime with singular effectiveness in a high proportion of patients.

It also is important that a record of attacks be kept by the patient or by his family. There is no other objective manner for assessing the effectiveness of drugs. Neither the electroencephalogram, even if taken continuously, nor blood levels, even when in an effective therapeutic range, can substitute for an adequate record of attacks kept by the patient. The determination of blood levels may be of help in detecting causes for failure of control by revealing that the patient is not taking medication as prescribed or that some metabolic abnormality prevents its appropriate utilization.

At this time the drugs of choice for the control of seizures, other than absence or petit mal and certain other minor forms, are phenobarbital, diphenylhydantoin, and possibly primidone. In January 1966, a double-blind comparison of these three drugs revealed that they were about equally effective with a tendency for diphenylhydantoin to be slightly superior.[10] This same study revealed that the drugs could be used in combination effectively to avoid side effects. The results suggested that the anticonvulsant effects of the drugs were additive and that the side effects were not. Thus, a patient unable to tolerate sufficient quantities of a single drug might respond favorably to half as much of two drugs combined; for example, 150 mg each of diphenylhydantoin and phenobarbital in place of 300 mg of either alone. Others have stated that the equivalent dosages of the drugs are phenobarbital 30 mg, diphenylhydantoin 90 mg, and primidone 200 mg.[11] The total daily dosages for these three would range between 15 to 600 mg for phenobarbital, 25 to 600 mg for diphenylhydantoin, and 50 to 1000 mg for primidone depending upon the age and tolerance of the patient.

In 1952, the *Journal of the American Medical Association* published the results of an evaluation of standard anticonvulsant therapy in 329 patients.[12] A variety of patients was studied including those with single seizure types, those with more than one type of seizure, and patients with symptomatic as well as idiopathic epilepsy, or as they defined it "epilepsy of unknown etiology." Neither multiple seizures nor a variety of etiologies seemed to have any significance in relationship to the results. Using all drugs available at that time, including some still in the experimental form, they were able to achieve control of 48% and significant improvement in 37% for a total of 85%; failing in only 15%. Of those patients with single types of seizures, it was possible to achieve improvement or control in 87% of grand mal, 78% of psychomotor attacks, and 95% of focal seizures; an overall average of 86%. Of those with multiple seizures, 84% of one or more of the types of seizures was controlled or improved, but in only 49% were all seizure types improved in the same individual. Their results may not have been optimum as they probably included some patients with petit mal or absence without specifically directing therapy towards such seizures. In addition, of the 165 patients who were only improved or remained uncontrolled, only 60 or 36% had an adequate trial of the drugs for a variety of reasons. The adequate trial of a drug has never been achieved until it has been used in sufficient quantities to produce either control or toxicity.

Of great interest in this particular report is the fact that control or improvement was achieved with the use of diphenylhydantoin and phenobarbital singly or together in 79%. The use of all other drugs available at that time improved results by only an additional 6%. It is probable that primidone was included in "all others" since it was in 1952 that the first clinical report of this drug appeared in the literature.[13] Therefore, it is fair to conclude that diphenylhydantoin and phenobarbital, and possibly primidone are the drugs of choice. They did not state the specific amounts of phenobarbital used, but did indicate that a total daily dosage of diphenylhydantoin ranging around 300 to 400 mg was effective in the majority of patients, and in patients requiring both drugs the addition of 100 mg of phenobarbital to the usual dose of diphenylhydantoin was found to be highly

effective. All three of these compounds have the added advantage of producing few serious side effects.

For the treatment of petit mal or absence seizures, other types of drugs are required. The drug of choice for the treatment of this class of seizures at the present time appears to be ethosuximide. Studies since its introduction in 1958 suggest that about 90% of patients will benefit from its use and about three-fourths of these patients will achieve control or significant reduction in the numbers of seizures. This drug is chemically related to others: phensuximide (Milontin) and methsuximide (Celontin), predecessors which have been less successful.

Ethosuximide has the advantage of being well tolerated with few serious side effects having been reported. In contrast to other preparations used for the control of petit mal, serious blood dyscrasias are infrequent. The effectiveness of this preparation can be evaluated promptly, and a judgment as to its continued use probably can be made within the first 10 to 30 days. Its use should follow the same principles as outlined previously and the total daily dosage required may range between 250 and 1000 mg. The exact fate of this drug is not known, and it may have to be given more frequently throughout the day. Unfortunately in this country it is available only in fairly large capsules, and since petit mal is a disease of childhood, this may complicate its usage. This difficulty can sometimes be circumvented by placing the bottle of medication in the family freezer. The frozen capsules can be sliced, either to permit divided doses or to facilitate swallowing.

Prior to the advent of ethosuximide, the drugs of choice for this class of seizures and drugs which still find usefulness were the diones, trimethadione and paramethadione. The same principles of usage apply to these drugs, and they can be counted on to have a high degree of effectiveness in the control of seizures. Unfortunately both have potentially dangerous side effects, and serious blood dyscrasias have been reported after the use of either. In addition a nephrotic syndrome can be induced by either of these preparations, and once this has occurred they must never be used again.

With trimethadione a common beginning dose would be 150 mg three times a day, but the use of total daily dosages of 1200 to 1800 mg may be necessary. The range for paramethadione would be between 300 mg three times a day to as much as 2400 mg daily. Both of these preparations come in solutions as well as in other forms more acceptable to young children.

As mentioned earlier, many other preparations are available for our use in the event that the ones mentioned previously fail. Other barbiturates at our disposal include methobarbital (Mebaral) and metharbital (Gemonil). Both of these derivatives are simple methylated compounds, and in the body methobarbital is metabolized to phenobarbital, and metharbital to barbital, and are simple weak forms of the parent compound.[14] Recently doubt has been raised as to the anticonvulsant effect of primidone independent from its conversion to phenobarbital. In one study of 19 adult patients who had been under treatment with primidone for more than one year, it was replaced by phenobarbital in quantities sufficient to maintain serum phenobarbital levels comparable to those obtained during the preceding yearly treatment with primidone.[15] During the subsequent 6 to 8 months of trial, comparisons between the electroencephalogram and the clinical state, before and after the exchange of drugs, showed no significant change. It was the suggestion of this study that about 25% of primidone is converted to phenobarbital, and that it is this which is the effective compound.

Other hydantoins at our disposal would include methylphenylethyl hydantoin (Mesantoin) and ethotoin (Peganone), a three-ethyl-five-phenylhydantoin. Methylphenylethyl hydantoins is an effective anticonvulsant, but unfortunately acts as a bone marrow suppressant and several cases of fatal aplastic anemia have resulted. There is some early evidence to suggest that ethotoin may be metabolized to the parent compound of diphenylhydantoin. Recently thiohydantoin (Albutoin [Co-Ord]) has been reported by Millichap and others as having effects comparable to diphenylhydantoin in control of grand mal seizures and that it may have fewer side effects.[16] However, as with all new anticonvulsants, cautious further appraisal is required and more recent studies suggest more side effects could be expected.[17] This drug has not yet been released for general use.

For the petit mal class of seizure, methsuximide and phensuximide may, at times, prove useful as well as drugs such as acetazolamide, quinacrine hydrochloride (Atabrine), the amphetamines, or even a ketogenic diet. These forms of therapy are less frequently effective and useful. The ketogenic diet is difficult to enforce in children. Acetazolamide is often of temporary value only. Quinacrine hydrochloride causes a yellow discoloration of skin and the amphetamines are quite variable in effect.

Certain special problems are encountered in epilepsy which may require some deviation from the usual forms of therapy. So-called infantile massive spasms frequently associated with an electroencephalographic pattern, known as hypsarrythmia, may require the utilization of ACTH or

other steroids in addition to the more standard forms of therapy in order to control seizures. Akinetic seizures or sudden drop attacks are extremely refractory to all of the usual drugs, and a frequently fruitless trial of tranquilizers, stimulants, muscle relaxants, and others may be necessary. Diazepam (Valium) may be helpful.

Status epilepticus presents a special problem, as it represents a medical emergency with a high degree of mortality and morbidity even when sophisticated treatment methods are applied. Until recently, the drug of choice was phenobarbital given intramuscularly or preferably intravenously in doses ranging from a few hundred milligrams to as much as 2 to 3 grams over a period of several hours. Some studies have advocated paraldehyde.

In the past few years, there have been a number of enthusiastic reports about the value of diazepam[18, 19] for the control of status epilepticus. Except in the presence of a devastating intracranial lesion, intravenous doses, ranging from 5 to 10 mg repeated two to three times at 20-minute intervals seem to achieve control. Reports of its value have ranged from almost 100% effective to a low success rate of about 85%.

It is difficult to establish concrete guidelines for the therapy of seizures. With few exceptions specific drugs do not act upon specific seizure types. An adequate dosage of drug is frequently difficult to calculate, purely on a dose-weight relationship. There is no objective manner for assessing the efficacy of therapy other than through seizure counts. The benefits derived must always be weighed against the side effects produced. Following certain principles, however, will achieve the best results in the largest numbers of patients. The need for classifying seizures properly, the need for cooperation between patient and physician, the need for a systemic and persistent use of medication, and the need for using simple, safe preparations first is emphasized. □

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POOLED PLASMA

Following disclosure in a University of Southern California study that 10 percent of patients given pooled blood plasma develop infectious hepatitis, manufacturers have agreed to remove the product from the market. The official recommendation was made by the National Research Council's Committee on Plasma and Plasma Substitutes following a three-year study; the recommendation was backed up by a "voluntary compliance request" issued by the Division of Biologic Standards, National Institutes of Health.—From *International Medical Digest*, July 1968 □

THE HANDICAPPED WORKER has not only shown himself to be a good and competent employee; he frequently brings something extra in the way of motivation. He tries harder because he wants to show what he can do. As a result, employment of the handicapped is no longer regarded as an act of compassion; it is a matter of good business judgment. . . . Thomas J. Watson, Jr., chairman of the board, IBM Corporation. □

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Experiences with a "Cook Book" Operated Coronary Care Unit in a 145-Bed General Hospital

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■ THE ORIGINAL INTENT of a coronary care unit (CCU)[1, 2] was to provide an area containing all the necessary trained personnel and equipment essential to hopefully resuscitate a patient with myocardial infarction who was undergoing sudden death. The emphasis was on the treatment of otherwise fatal arrhythmias. Properly, the emphasis now has shifted to the prevention of these arrhythmias.[3, 4]

The shift in emphasis from treatment to prevention has increasingly demanded that a "cook book" of standing orders be detailed allowing the CCU nurses the authority not only to treat arrhythmias by electrical cardioversion or pacemaking but also to attempt to prevent them by the immediate administration of drugs both by mouth and vein to control the emergent minor arrhythmia, cardiogenic shock, or cardiac decompensation predisposing to serious arrhythmia and sudden death.

This transition to prevention has placed CCU nurses in the new perspective of initiating potentially life-saving procedures with often highly toxic drugs solely on the basis of their own clinical judgment. Such judgments are classically reserved for physicians. However, even in hospitals having a house staff this transition has occurred and the importance of adequately trained nurses has become paramount. The future may well witness this role played by the trained technician or by a computer.

This report will outline the experiences in the four-bed Wausau Memorial Hospital Coronary Care Unit. The CCU opened in April 1967, and except for a brief closing during a time of insufficient trained personnel, has operated continuously since that date.

This report deals with the CCU's first seven and one-half months of operation, compares the results of this operation to those found during a comparable period prior to opening the CCU, and outlines the success of the trained nurse initiating potentially life-saving procedures on her own initiative according to the dictates of multiple standing orders in a CCU "cook book" of treatments and procedures.

Data Analysis

An analysis of the 76 consecutive patients admitted as acute myocardial infarction suspects to the CCU during the first seven and one-half months of operation comprises the body of this report. In 53 of these 76 patients this suspicion was confirmed by appropriate serial studies. Similarly, the records of 10 patients with myocardial infarction who for some reason were not admitted to the CCU were reviewed. Thus a total of 63 patients with acute myocardial infarction were admitted to Wausau Memorial Hospital during this study period.

The average CCU stay for the 53 patients was 6.4 days; for the remaining 23 patients, 3.8 days. Thus the total patient CCU hospital days was 447 and there was an average of approximately 2 (1.98) coronary patients in the CCU at all times. This census proved to be only slightly less than ideal for operation of a four-bed coronary care unit. Patients with myocardial infarctions are rarely admitted on a two-a-day occupancy rate basis. The CCU was commonly filled but rarely overflowing or empty. Because of this less than optimal use, it was found advisable to have the CCU double as an intensive care unit when not fully utilized by coronary patients. Such a double function is not only more economical but also has the added benefit of keeping the trained, dedicated nurses stimulated and interested.

The 53 patients with proven myocardial infarctions were retrospectively divided into two groups on the basis of their clinical condition on admission. Patients not having significant shock (systolic blood pressure less than 90 mm Hg, mental obturation, oliguria, or significant diaphoresis) and/or severe cardiac decompensation were classified as "good," while those with one or both of these complications were classified as "other." For comparative purposes

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TABLE 1—*Comparative Experience in the Wausau Memorial Hospital with 105 Myocardial Infarction Patients Treated Prior to and After Starting a Coronary Care Unit (CCU)*

	Prior to CCU Condition of patient**				After CCU* Condition of patient**			
	Good		Other		Good		Other	
	37 Patients No.	%	15 Patients No.	%	36 Patients No.	%	17 Patients No.	%
Age:								
Average (years)	60		69		61		65	
Range: 30's	1	19	0	7	0	19	0	18
40's	6		1		7		3	
50's	10	27	2	13	9	25	4	24
60's	14	38	7	47	12	33	4	24
70's	4		4		8		2	
80's	2	16	1	33	0	22	3	35
90's	0		0		0		1	
Sex:								
Females	10	27	6	40	4	11	6	35
Males	27	73	9	60	32	89	11	65
Mortality:								
While in CCU					0	0	7	41
When not in CCU	10	27	6	40	2	5.6	0	0
Total (%)	16 (30.8%)				9 (17.0%)*			

*For unknown reasons ten patients ranging in age from 40 to 83 years with acute myocardial infarctions were not admitted to the CCU during this period. Five of these would have been classified as "good" with one death and five as "other" with three deaths for a mortality rate of 40.0%. Including these ten patients the total hospital mortality for all patients (63) having myocardial infarction was 20.6%.
**See text.

TABLE 2—*Cause of Death in 9 of 53 Coronary Care Unit Treated Patients*

Irreversible Cardiogenic Shock and/or intractable cardiac decompensation (pump failure):	
With terminal standstill	3
With terminal ventricular fibrillation	1
Myocardial rupture	1
Acute Cerebrovascular Accident*	1
Terminal uremia	1
Unknown	2

*Autopsy refused; performed in the remaining eight patients.

a similar retrospective analysis of 52 consecutive myocardial infarction patients admitted prior to April 1967 was made.

Comparative Experience in the Two Patient Groups Prior To and After Opening the CCU

The comparative experience in these two groups of myocardial infarction patients prior to and after the CCU was started is depicted in Table 1. There were 52 patients in the former group and 53 patients in the latter. The age and sex distributions are roughly comparable. As expected the majority of the patients were males and the average age of the males (57.2 years) was less than that of the females (68.1 years). Likewise, the patients with cardiogenic shock and/or severe cardiac decompensation tended to be older than those without these complications.

The mortality differences were dramatic. Sixteen (30.8%) of the 52 patients in the prior to CCU group died while only nine (17.0%) of the 53 patients in the after CCU group died. Significantly, none of the 36 patients classified as in "good" condition died during their CCU treatment and only two of them died after they were transferred out of the CCU. This 5.6% mortality rate compares very favorably to the 27% mortality rate in the 37 "good" condition patients admitted prior to opening the CCU. It suggests that the lives of at least eight patients were saved during this period.

Unfortunately, the mortality rate of the patients not in "good" condition because of cardiogenic shock and/or intractable cardiac decompensation was not improved. Much progress needs to be made in the therapy of these unresponsive conditions.

Cause of Death in CCU Treated Patients

The causes of the nine deaths occurring in the 53 CCU treated patients are listed in Table 2. The two causes listed as unknown occurred in "good" condition patients doing well out of the CCU who died suddenly on their 12th and 27th hospital days. In the former patient procaine amide had been discontinued less than 24 hours prior to his sudden death. If this drug has been started, we now continue it for at least 14 days.

Nurse Initiated Treatments Based on CCU "Cook Book" of Standing Orders

The standing orders of the CCU "cook book" of treatments and procedures follows the general recommendations of Lown[3] and Kimball.[4] The details of these standing orders are too voluminous for this brief report. Suffice it to state that the trained CCU nurses were given authority to institute oral procaine amide therapy for any ventricular premature contractions, intravenous bolus and drip lidocaine therapy for any coupled ventricular premature contractions or those occurring on the vulnerable period of ventricular repolarization or those occurring more frequently than four per minute or for any ventricular tachycardia, intravenous atropine or isoproterenol and pacemaker operation (transvenous if prior physician placement) for significant bradyarrthy-

TABLE 3—*Incidence of Arrhythmias in 53 Patients Treated in a Coronary Care Unit for Myocardial Infarction; Results of Therapy Given on the Basis of Trained Nurse's Judgment*

Type of Arrhythmia	Patients Experiencing		Therapy Given		Therapy Successful	
	No.	%	Variety	No.	No.	%
Supraventricular:						
Tachycardia	6	11	(By MD's order)			
Atrial flutter	2	4	Ouab.	2	1[1]	50[1]
Atrial fibrillation	10[2]	19	Ouab.	4	3	75
Ventricular:						
Premature contractions	46	87	Proc. A.	46	?[3]	?[3]
			Lidoc.	27[4]	24	100
Tachycardia	12[5]	23	Lidoc.	10	6	60
			C-V	4	4	100
Flutter or fibrillation:						
Without pump failure	2	4	C-V	2	2	100
With pump failure	1	2	C-V, ABCs	1	0	0
Bradyarrhythmias:						
Sinus arrest or bradycardia	6	11	Isop.	2	2	100
			Atrop.	2	1	50
Second degree A-V block	5	9	TVPm	3	3	100
Third degree A-V block:						
With escape rhythm	2	4	Isop.	1	1	100
			TVPm	2	2	100
With standstill	1	2	EPm, Isop., ABCs, TVPm	1	1	100
Ventricular standstill from pump failure	3	6	EPm, Isop., ABCs, Etc.	3	0	0

Ouab: Ouabain i.v. as 0.25 mg bolus. *Proc. A.:* Procaine amide by mouth 250–500 mg every six hours. *Lidoc.:* Lidocaine i.v. as 40–80 mg bolus followed by continuous drip. *C-V:* direct current (D.C.) cardioversion. *ABCs:* Total resuscitation effort including closed chest cardiac massage. *Isop.:* Isoproterenol i.v. drip. *Atrop.:* Atropine i.v. as 0.4–0.8 mg bolus. *TVPm.:* Turning on transvenous catheter pacemaker previously inserted by physician. *EPm:* External pacing.

[1]One patient probably spontaneoulsy converted after a 0.25 mg bolus. The second patient had physician supervised D.C. cardioversion done by the nurse.
[2]Three patients had physician supervised D.C. cardioversion done by the nurse.
[3]The results of oral procaine amide therapy are difficult to evaluate.
[4]The "ventricular premature contractions" were actually bundle branch variants in three of these 27 patients (see text).
[5]Ventricular tachycardia spontaneously converted in two patients who did not receive a bolus of lidocaine.

thmias particularly if the patient demonstrated clinical evidence of decreased cardiac output, intravenous ouabain for atrial flutter or uncontrolled atrial fibrillation, unsupervised cardioversion for ventricular flutter or fibrillation and for ventricular tachycardia unresponsive to lidocaine, as well as sedation, artificial respiration, and closed chest cardiac massage as indicated (Table 3).

Some form of nurse initiated oral or intravenous drug therapy was given to virtually all of the 53 patients with acute myocardial infarction as well as to some of the 23 patients admitted to the CCU as infarction suspects. Intravenous drug therapy was instituted in 43 patients (81%). Twenty-nine patients were given lidocaine (many repeatedly) and six patients ouabain. In all these instances of nurse initiated intravenous therapy the patient was unequivocally benefited. No patient received a not indicated direct current cardioversion. Such successful electrical therapy was given at the attending nurse's judgment in six patients. Four additional patients were electively treated under the supervision of a physician.

In the entire series of 76 patients there were only five misdiagnoses, and therefore treatments at variance with the standing orders were administered. Two of these errors also might have been made by the experienced electrocardiographer. One supraventricular tachycardia and one very rapid, uncontrolled atrial fibrillation were associated with aberrant intraventricular conduction and treated as ventricular tachycardia. In neither instance was the patient harmed. Indeed, the uncontrolled atrial fibrillation promptly converted to a normal sinus rhythm after an 80 mg intravenous bolus of lidocaine at which time the nurse readily recognized the bundle branch abnormality. In three patients transient bundle branch variants were erroneously diagnosed as consecutive ventricular premature contractions and treated with intravenous lidocaine. In none of these instances did the patient experience any damaging effects.

Summary

These experiences with a "cook book" operated coronary care unit (CCU) in a 145-bed general hospital demonstrate the following points:

1. A four-bed CCU can be successfully operated in a hospital averaging approximately seven to eight admissions for myocardial infarction per month. Hospitals having such a relatively small number of admissions for myocardial infarctions would be wise to have their CCUs double as an intensive care unit when not fully occupied by coronary patients. Such double use not only is more economical but also has the added benefit of utilizing the special talents of the CCU nurses and of keeping these dedicated nurses stimulated.

2. A CCU can be successfully operated by trained nurses initiating therapy on the basis of their own clinical judgment according to multiple standing orders.

3. Properly trained CCU nurses allowed to operate in this manner can significantly reduce the mortality rate from myocardial infarction chiefly by prevent-

ing, but also by promptly treating, otherwise fatal cardiac arrythmias.

4. The treatment of myocardial infarction patients with irreversible cardiogenic shock and/or intractable cardiac decompensation (pump failure) is in dire need of improvement.

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ORAL ANTIBIOTIC BOWEL PREPARATION AND COMPLICATIONS IN COLON SURGERY

MICHAEL A. POLACEK, MD, and PETER SANFELIPPO, MD, Milwaukee, Wis.: *Archives of Surgery* 97:412–417 (Sept) 1968

Two hundred and seventy consecutive cases of open surgery were reviewed. Seventy percent of the patients received oral antibiotic preparations with mechanical cleansing enemas and low residue diets as compared to 30% of the group which did not receive any oral preoperative antibiotics. The nonoral antibiotic group was given parenteral antibiotics on the day and three days following surgery, with chloramphenicol and penicillin the usual agents of choice. All complications in the group of patients on oral antibiotics totaled 50% with diarrhea the main problem (27%). Infections occurred in 23% of this group. Total complications in electively prepared patients not receiving oral antibiotics, but having cleansing enemas and parenteral antibiotics, was 4%—all infections without any diarrhea reported. Postoperative fulminating staphylococcal enteritis was a rare sequel to colon surgery, with or without the use of antibiotic bowel preparation, and did not contribute to any mortality. However, staphylococcal wound infections in the patients on oral antibiotic therapy were significantly higher than in the group not receiving oral antibiotics. This appeared to corroborate the work of others who have shown that patients on oral antibiotic bowel preparation have a high incidence of staphylococcal pathogen overgrowth.

There is no doubt that antibiotics have lowered the incidence of postoperative infections in open colon surgery. Nevertheless, there are inherent dangers in the use of oral preoperative antibiotics, especially pathogen overgrowth. Endogenous staphylococcal overgrowth appears to be increasingly a dangerous problem, not because of fulminating enteritis, but rather as a possible contributing factor to wound infections in these patients. In the last 25 years, there have been other advances besides oral antibiotic bowel preparation which have had an effect on the lowered incidence of infectious morbidity in colon surgery. Improved surgical technique, intensive support of treatment, and the judicious use of systemic antibiotics all have contributed to improve the overall results in colon surgery. □

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EFFECTS OF AUTOMATION ON LABORATORY DIAGNOSIS

GEORGE Z. WILLIAMS: *Calif Med* 108:43 (Jan) 1968

Laboratory medicine is assuming a central and indispensable role in all phases of health evaluation and medical management. Use of multiphasic test profiles for initial evaluation of patient's problem and as a part of the routine complete examination is revealing unsuspected abnormalities. Larger and more complex batteries of tests are needed for daily evaluation of the patient's progress and guidance of therapeutic management. The existing shortage of manpower and space resources for the laboratory is becoming acute.

Clinical pathologists are meeting this challenge by intensive programs for development of automated, mass production methods with improved accuracy, reliability, and lower cost. Laboratory medicine of the future must make available complete laboratory services.

Carefully designed computer programs will compare new test results with previous results on the same patient and report any deviation or abnormality as compared with the patient's normal ranges. There are beginnings of programs to provide high-speed computations of physical and chemical data to assess complex physiologic balances as they exist in the individual patient and to compute the necessary therapeutic measures to return the bodily processes to normal.

A large part of the initial periodic health examination routine can be assumed by appropriate combinations of multiphasic laboratory screening tests. Automation can spare a physician much of the tedious and time-consuming, routine physical examination. He will have a comprehensive laboratory report to help guide the further examination of the patient.

These advances impose a greater responsibility on both the physician and the laboratory personnel. Serious hazards to the patient's health from misinformation are more likely with automation unless careless use is avoided. The potential of automation generates a tendency to overconfidence, to uncritical acceptance of results, and to relaxation of the traditional surveillance of physicians for the protection of patients. Automation does not assure reliability. Computers can make and perpetuate errors.

The physician must satisfy himself that the laboratory on which he depends is reliable. Periodically, duplicate samples should be submitted on different days to compare the results. □

Segmental Fibromuscular Dysplasia of the Renal Artery with Secondary Hypertension

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■ FIBROMUSCULAR DYSPLASIA or hyperplasia of the renal arteries producing renal artery stenosis and secondary hypertension is now a well recognized clinical entity.[1-3] There appear to be several pathologic subdivisions or variants of this disease process and the case to be presented illustrates one of these variants. The predictive or prognostic values of renal vein renin activity has also been the subject of a number of reports[4-10] and were of definite value in the prognosis of the case reported here.

Case Report

A 25-year-old farmer was referred to this clinic in August 1967 for evaluation of hypertension (200/120 mm Hg) noted six weeks previously, which had failed to respond to the usual milder antihypertensive medications. His only symptoms were excessive fatigue and occasional early morning headache. A sister who is a registered nurse also has hypertension.

Physical examination revealed body weight of 163 lbs. Blood pressure ranged from 170–190 mm Hg systolic over 120–140 mm Hg diastolic. The remainder of general physical examination was not remarkable. There was no abdominal bruit. Normal laboratory studies included urinalysis, hemogram, blood sugar, blood urea nitrogen, and cholesterol. Serum sodium was 137, potassium 3.8, chloride 99.5, and carbon dioxide 28.9 mEq/liter respectively. Protein bound iodine was 7 mcg/100 ml, 24-hour catechol amine less than 180 mcg, and vanilmandelic acid 6.1 mg in 24 hours. The chest x-ray film and resting electrocardiogram were within normal limits. The timed intravenous pyelogram revealed slightly more contrast media in the right kidney in three minutes than in the left, and the right kidney measured 14 cm total length as opposed to 13 cm on the left. The renal arteriogram (Fig 1) revealed a stenotic lesion which involved the left main renal artery approximately 1 cm from its origin with associated post-stenotic dilatation. The right renal artery and all of its peripheral branches were normal. The renin levels by the method of Boucher et al[11] were left renal vein 2,200 ng/100 ml plasma, right renal vein 570 ng/100 ml plasma, right atrium 840 ng/100 ml plasma respectively.*

Surgical exploration confirmed the presence of a left renal artery stenosis which gave the appearance of a "coarctation." The stenotic area was resected and an end-to-end anastomosis performed, following which there appeared to be good distal flow. A postoperative intravenous pyelogram was normal, and a repeat renal arteriogram (Fig 2) revealed a satisfactory surgical result. The nephrogram showed the left kidney to be larger than preoperatively, with a maximum length of 13.8 cm and a width of 6.5 cm, which is a 1 cm increase in length and a 0.5 cm increase in width. Postoperative blood pressures continued in the normotensive range, 130–140/90 mm Hg, and peripheral venous plasma renin activity was normal at 250 ng/100 ml plasma.

Discussion

The pathologic subdivisions of fibromuscular hyperplasia which have been proposed by various

Fig. 1—Preoperative angiogram showing stenotic lesion of the left renal artery with post-stenotic dilatation.

Fig. 2—Postoperative angiogram. The stenotic area was resected and end-to-end anastomosis performed.

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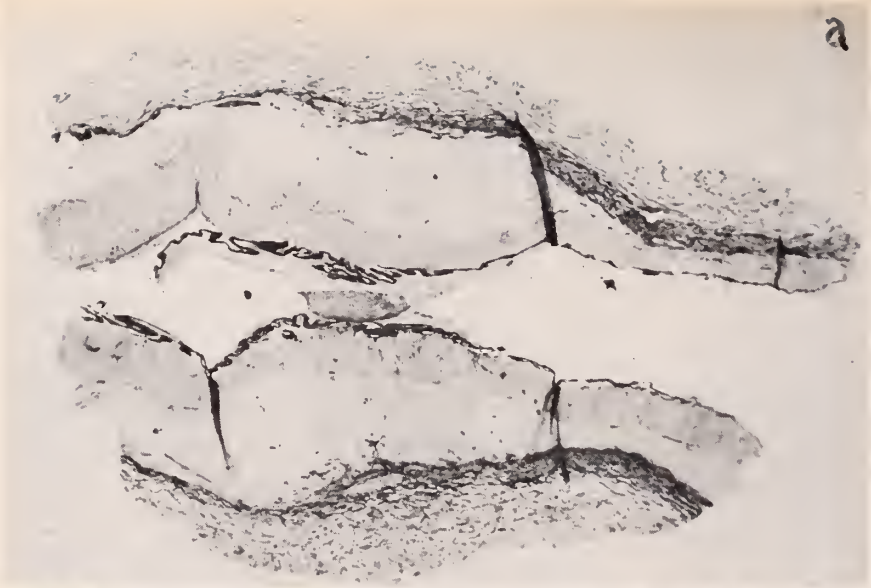
* ng = nanogram. A nanogram is equivalent to 10^{-9} grams or 1 millionth of a milligram. This is the unit now used by investigators carrying out renin determinations and determinations of other substances which are found in low concentrations. It avoids the use of decimal points and zeros if one would use milligrams or micrograms.



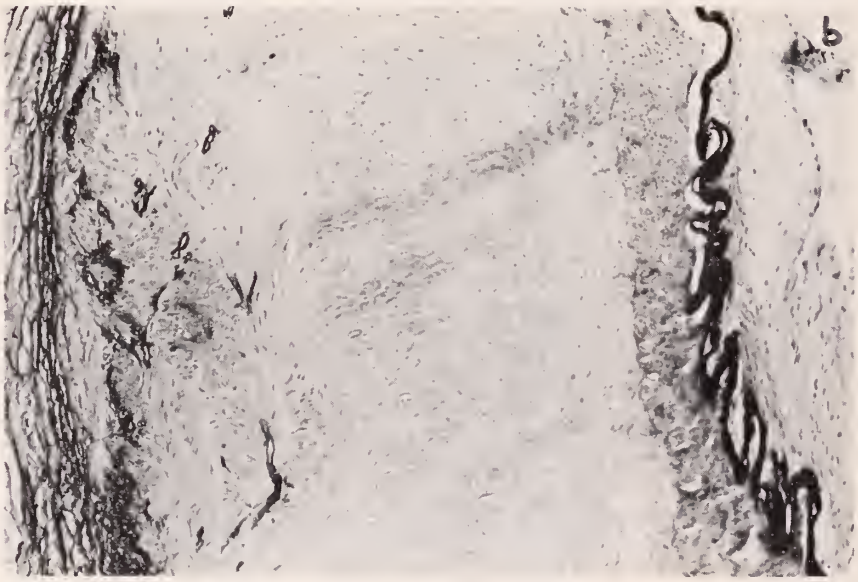


Fig. 3—Longitudinal sections of resected segment of left renal artery (Vernoeff's elastic stain). (a) 10X localized intimal ridging with replacement of the outer ⅔ of the media by collagen, fibrous tissue and occasional strands of smooth muscle fibers (b). (b) 40X also note disruption of the external elastic lamina with apparent increase of the vasa vasorum.

authors are surprisingly similar. The following classification was proposed by McCormack et al in 1966:[1]

(1) Intimal fibroplasia,
(2) Medial fibroplasia with aneurysm formation,
(3) Fibromuscular hyperplasia, and
(4) Subadventitial fibroplasia.

In the first group, intimal fibroplasia, the changes take place internal to the internal elastic lamina, and care must be taken to exclude arteriosclerosis. This is an intriguing lesion and appears to be a counterpart of arteriosclerotic change that can involve any artery of the body. The second group, medial fibroplasia with aneurysm formation, shows the characteristic sausage string or string of beads deformity on aortography. This lesion is found predominantly in the renal artery, although a rare similar lesion has been seen in other areas of the body. Palubinskas et al[12] reported lesions involving the superior mesenteric celiac external iliac, extra- and intracranial carotid arteries with associated aneurysm formation. The third group, fibromuscular hyperplasia, in which there is a haphazard arrangement of muscle fibers and fibrous tissue in the media, was the rarest type encountered by McCormack.[1] The fourth group, subadventitial fibroplasia, appears to be a unique lesion which occurs predominantly in young women and apparently involves only the renal artery. Pathologically it consists of a collar or cuff of dense collagen that surrounds the renal artery for variable lengths and variable thicknesses. In many instances it replaces the outer layers of the media and involves the elastica externa. The arteriogram may give the appearance of beading, but careful observation discloses that the caliber of the vessel is not distended by the bead.

Histologically the lesion in the patient described in this report (Fig 3) fits into the fourth group, subadventitial fibroplasia. The segmental nature of the lesion is quite interesting and, as mentioned previously, gave the appearance of a coarctation at the time of surgery.

Peripheral vein renin levels in renovascular hypertension correlate poorly with surgical success or failure. Theoretically more promising, and demonstrated in our case, is the prognostic value of the differential in plasma renin level in the renal vein of the affected kidney as compared to its counterpart, and the suprarenal vena cava.

A recent study demonstrated that an increased suprarenal level gave an overall predictive accuracy of 87%.[8] The authors stated that the increased renin activity in the renal vein may conceivably result from a reduction of renal blood flow accompanied by a normal secretion rate, just as it can be due to an absolute increase in secretion rate. This case report indicates the absolute necessity of obtaining blood samples from the renal veins and the suprarenal vena cava before surgery is attempted on patients with renovascular hypertension.

Summary

The case presented illustrates one of the anatomic and pathologic variants of fibromuscular dysplasia of the renal artery with associated secondary hypertension. Surgical correction resulted in an excellent postoperative blood pressure response. The renin activity from the vein of the involved kidney correlated well with the surgical success.

ACKNOWLEDGMENT. The authors are indebted to Dr. Sidney Johnson of the Marshfield Clinic for referral of this patient.

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MANAGEMENT OF COMPLETE HEART BLOCK COMPLICATING ACUTE MYOCARDIAL INFARCTION

M. E. SCOTT, J. S. GEDDES, G. C. PATTERSON, A. A. J. ADGEY, and J. F. PANTRIDGE. *Lancet* 2:1382 (Dec 30) 1967

Fifty patients with complete heart-block complicating myocardial infarction were studied. Twenty-three were managed initially on drug therapy (isoprenaline, corticosteroids, and a glucose–insulin–potassium regimen); the remaining 27 had endocardial pacing as the initial therapy. The patients ranged in age from 37 to 79 years.

Of the 50 patients, 26 (52%) survived to leave the hospital. Of those who received drug therapy initially, 61 percent died, in contrast to 37 percent of those who were immediately paced.

Prognosis depends on the degree of circulatory disturbance, age, site of infarction, and the interval between infarction and the development of heart-block. In the patients with mild circulatory disturbance the mortality was nil, in the moderately severe group it was 46 percent, and in the severe group it was 92 percent. The mortality was higher among the older patients, which is accounted for by a higher incidence of severe circulatory disturbance. Ten (59%) of 17 patients with anterior infarction died, compared with 11 (37%) of 30 patients with inferior infarction. The prognosis was worse when block developed within 24 hours of infarction.

Six (86%) of 7 patients who had Stokes–Adams attacks and were treated with drugs died. Of the 14 patients with Stokes–Adams attacks who were paced immediately, 5 (36%) died.

Ventricular fibrillation developed in 12 patients (24%); 7 survived. Three patients had had ventricular fibrillation before heart-block developed. In 2 patients fibrillation first occurred after atrioventricular conduction had returned. A third patient developed tachyarrhythmia three weeks after infarction. The onset of ventricular fibrillation was related to infusion of isoprenaline in 3 patients and to manipulation of the pacemaker in 3 others. Three of these 6 patients had more than one episode of ventricular fibrillation besides that which developed in association with isoprenaline or pacing; thus, ventricular fibrillation developed in 9 patients irrespective of therapy.

Three of 9 patients returned to 1/1 atrioventricular conduction while on oral sustained-action isoprenaline; 5 of 9 patients resumed atrioventricular conduction during intravenous infusion of isoprenaline and 4 did so within 24 hours.

Atrioventricular conduction was resumed in 20 of the 27 patients who were paced immediately. Conduction returned in 3 within 24 hours.

In 30 patients atrioventricular conduction was resumed and persisted for 24 hours or longer. One of these patients had grade 1 heart-block on discharge and was readmitted because of recurrent complete heart-block. In another, complete heart-block recurred repeatedly, necessitating the use of a demand pacemaker for two weeks. Both patients subsequently died.

It is suggested that immediate pacing is required in patients with complete heart-block who show severe hypotension or evidence of cardiac defeat or who have had a Stokes–Adams attack. □

Experimental Observations on Adult Enlarging Skull Fractures

A PRELIMINARY REPORT

By LARRY M. FREEMAN, M.D., DOROTHY L. ROSENTHAL, M.D. and FRANK P. GOLDSTEIN, M.D., Milwaukee, Wisconsin

■ GROWING FRACTURES of childhood have been described in humans and simulated in an experimental model using puppies.[1] Clinically, these uncommon growing fractures are seen only in infants and children. A review of the literature and discussion of clinical features and problems were presented in 1961 by Lende and Erickson.[2] Other cases subsequently have been reported.[3, 4] The following investigation was designed to consider whether a growing animal with an expanding cranial vault is essential for producing an enlarging skull fracture.

DR. LARRY M. FREEMAN presented the winning resident paper at the Annual Meeting of the State Medical Society of Wisconsin, May 16, 1968, in Milwaukee. He was given $100 as the Harry Beckman Award. Doctor Freeman is currently an Assistant Instructor of Surgery, Marquette School of Medicine, Milwaukee County General Hospital.

Materials and Methods

Five adult mongrels were used. Each animal was anesthetized with intraperitoneal pentobarbital sodium (Nembutal). A midline vertex scalp incision and bilateral rectilinear osteoplastic parietal bone flaps were made using a dental disc 1 mm in thickness (Fig 1). The bone flaps were hinged on the temporalis muscle. Additional procedures on meninges were carried out in the region underlying the anterior limb of the craniotomy on each side. The other three limbs of each flap served as controls. In the anterior limb, a cerebrospinal fluid-containing pouch was made by incising the dura and arachnoid and suturing pericranium to the dural edges (Fig 2).

All bone flaps were sutured into normal position after the preparation of the cerebrospinal fluid containing pouch. Immediately after operation, x-ray films of the skull were taken. Later, more were taken at suitable intervals to determine if, in fact, an expanding craniotomy line ("growing fracture") occurred in the experimental limb as compared to the normal healing process which was expected in the control limbs.

The animals were sacrificed when the films revealed that bone healing had occurred or an enlarging craniotomy line had developed. A cranial cap that included pericranium, bone, meninges, and brain was removed en bloc. The specimen was fixed in 10% formalin, and roentgenograms of the cranial cap were taken. After decalcification, longitudinal sections of the experimental and control sites were made. Histological sections were stained with hematoxylin-eosin, van Gieson, and Gomori's trichrome stains.

Results

All control limbs healed normally. In five of the ten experimental limbs an enlarging fracture line occurred, as was confirmed by x-ray and pathological examination of the specimens.

Sections taken from areas showing rarefaction or separation of the edges revealed erosion of the bone edges. This was always more severe in the inner table. Histologically, the edges of the eroded bone appeared in some instances consistent with pressure atrophy with no apparent cellular reaction; in other cases osteoclastic activity was observed at the edges, undoubtedly contributing to the erosion. In addition to the erosion of the bone edges, the tissues within the craniotomy line usually showed outward bulging. In some cases we found that a portion of the brain fitted rather snugly into the inner aspect of this bulge.

In other cases small cysts were formed within the fibrous tissue connecting the bone edges. These were filled with a clear translucent fluid which stained a very faint pink color with hematoxylin-eosin. It was no longer possible to identify pia, arachnoid, or dura in the fibrous wall of these cysts (Fig 3).

Discussion

Taveras and Ransohoff[5] proposed a mechanism for the production of expanding fractures: "Trauma produces a skull fracture and an underlying dural tear. At the same time there is probably sufficient subarachnoid hemorrhage to hinder the local circulation of cerebrospinal fluid. The arachnoid membrane projects out through the dural tear into the fracture site. This trapped arachnoidal hernia, aided by the

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normal pulsations of the brain, gradually erodes the edges of the bone and at the same time compresses the underlying cortex. There must be some degree of ball valve mechanism at work also, with the cerebrospinal fluid having easier ingress into, than egress from the cyst. Arachnoidal adhesions about the margin of the lesion probably also play a part in trapping the fluid locally. The authors felt that the dural tear is the single most important factor in the pathogenesis of these lesions and that without it the fracture would heal as expected."

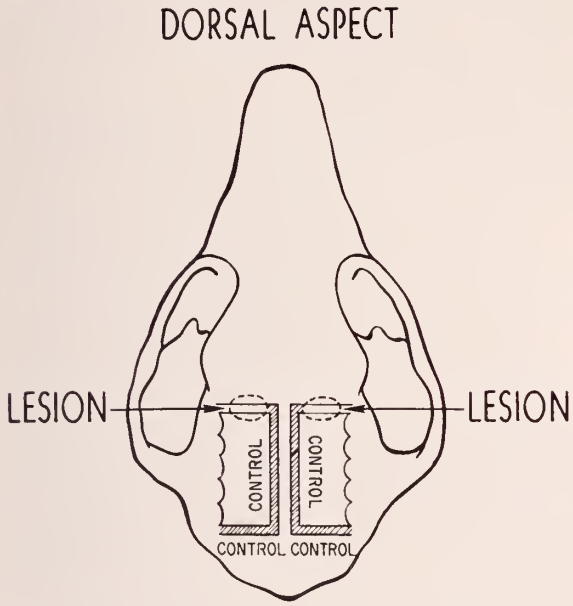

Fig. 1—Diagram of bilateral rectilinear osteoplastic parietal bone flaps. Lesion in anterior experimental limb is indicated.

Experimentally, Muller[6] advanced the hypothesis that the endocranial surface is molded by the surface of the arachnoid which in turn duplicates the contours of the brain because it is held in place by the arachnoid trabeculae. Darlington[7] showed that experimentally induced irregularity in the surface of the brain imprinted itself on the inner surface of the skull. Keener[8] studied the effect of dural defects under normal bone and concluded that the primary

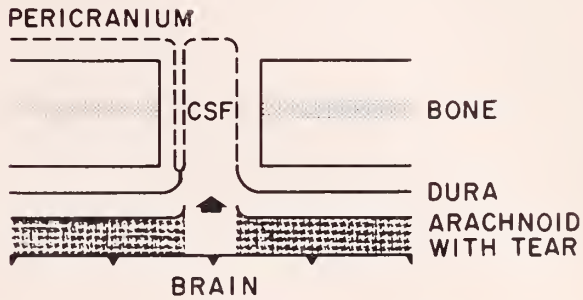

Fig. 2—Diagram of method used to produce in the anterior experimental limb, a cerebrospinal fluid containing pouch by incising the dura and arachnoid and suturing pericranium to the dural edges.

Fig. 3—Multiloculated cysts, in sections from areas revealing erosion of bone edges (enlarging fracture). (Small arrows = cysts; large arrows = bone edges.)

pathology in the production of growing fractures of childhood was the presence of a persistent dural defect. Goldstein[1] showed that enlarging fractures could be produced experimentally in newborn puppies if a dural pouch and open arachnoid were produced.

Since there are no cases of adult growing fractures described in the literature, it was felt that an enlarging cranial vault was necessary to produce a growing fracture, as indicated by Muller. In our investigation all the craniotomy limbs used as controls healed normally. Fifty percent of the experimental limbs failed to heal and demonstrated brain cysts with expanding craniotomy lines. These results indicate that in the experimental animal it is not necessary to have a growing animal with an expanding cranial vault to produce a growing fracture.

Summary

Ten rectilinear craniotomies were done in adult dogs to simulate fracture lines. In each, three control limbs of the craniotomy healed normally. Fifty percent of the experimental limbs failed to heal and demonstrated brain cysts with expanding craniotomy lines. We conclude that in adult mongrel dogs it is not necessary to have a growing animal with an expanding cranial vault to produce a growing fracture.

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SUDDEN UNEXPECTED DEATH FROM NATURAL CAUSES IN YOUNG ADULTS: A REVIEW OF 275 CONSECUTIVE AUTOPSIED CASES

JAMES L. LUKE and MILTON HELPERN—*Arch Path* 85:10 (Jan) 1968

Cases of sudden and unexpected death from natural causes in 275 individuals between the ages of 20 and 45 years are reviewed.

There were 105 (38%) deaths related to the circulatory system. Seventy-eight (28%) were the direct result of previously asymptomatic severe coronary artery disease. Only 9 of the 78 victims lived long enough to be admitted to a hospital.

There were 27 deaths attributed to abnormalities of the circulatory system which did not involve primarily coronary artery disease and its complications. Causes of death were pulmonary thromboemboli (11), rheumatic heart disease with cardiomegaly (5), 2 each of pelvic and broad ligament thromboemboli, subacute bacterial endocarditis, acute pericarditis, and ruptured dissecting aneurysm, and one each of myocarditis, idiopathic cardiomyopathy, and sarcoidosis involving the myocardium. Both patients with acute pericarditis were alcoholics.

In 50 cases, autopsy revealed the cause of death to be principally in the respiratory system; 40 of these deaths were of an infectious nature. Twenty deaths resulted from fulminant active tuberculosis; 15 patients were chronic alcoholics. Eighteen deaths were attributed to lobar pneumonia. There were 2 deaths from infectious respiratory disease; one subject was an alcoholic. Death was attributed to bronchial asthma in 8 victims and to bronchogenic carcinoma in 2.

Fifty-eight persons died as a direct result of central nervous system disease. Massive subarachnoid hemorrhage accounted for 25 deaths, intracerebral hemorrhage for 21, acute bacterial meningitis for 7, a ruptured arteriovenous vascular malformation for 3, and an undiagnosed brain tumor for 2.

Of 37 deaths from disease of the gastrointestinal tract and related digestive organs, 13 were from massive upper gastrointestinal hemorrhage, 11 from acute hemorrhagic pancreatitis, 11 from acute peritonitis, one from hemoperitoneum, and one from disseminated gastric carcinoma. Most of these patients were alcoholics.

In 11 instances, the cause of death at autopsy was found to be located in the urinary tract. Of these, 8 deaths were from acute pyelonephritis, one from chronic glomerulonephritis, one from carcinoma of the urinary bladder, and one from polycystic kidneys. Four were chronic alcoholics.

Additional causes of death included complications of labor and delivery (4), diabetic acidosis and coma (3), sickle cell anemia (3), and one each of acute leukemia, sepsis, thyroid carcinoma, and melanoma.

Men outnumbered women by a 2:1 ratio. Negroes occupied a significantly larger percentage (53%) than the 25 percent that would be expected on a population basis.

The potentiating direct and indirect effects of acute and chronic alcoholism on natural disease processes of all types cannot be overemphasized and constitute a public health problem. Perhaps it was because of their alcoholism that many of these individuals failed to seek medical attention. □

THERAPEUTIC DILEMMAS

COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They are published in a selective manner monthly, except January.

Editor: HARRY BECKMAN, MD, Houghton Fellow in Clinical Research and Consulting Physician, Columbia Hospital

No. 18 of a Series

THE SYMPTOMATIC FUNCTIONING GALLBLADDER

Moderator: Glenn H. Franke, MD

Participants: Joan C. Paust, MD
Donald Shaw, MD
John O. Chamberlain, MD
John C. Weber, MD
Wayne J. Boulanger, MD
Philip H. Seefeld, MD
Philip B. O'Neill, MD

Dr. Glenn H. Franke: Truly we will be conferring today about a "therapeutic dilemma": what to do for the patient who appears to have symptomatic gallbladder disease in the absence of confirmatory x-ray findings. Internists, surgeons, and roentgenologists will be participating. Doctor Paust will present the case.

Dr. Joan C. Paust (Intern): A 58-year-old white man was admitted to this hospital on Feb. 26, 1968, with right upper quadrant abdominal pain of 5 hours' duration and of such severity that full depth of breathing was difficult. This was the third such attack he had had within the month, and upon each occasion contrast studies of the gallbladder had been inconclusive.

There was no history of jaundice, and the review of systems was noncontributory. His mother and father had died of cardiovascular disorders. He himself had had the usual childhood diseases but no known allergies. There was a long history of genitourinary difficulties. In 1943 a kidney stone passed spontaneously. In February 1967 he underwent manipulation and extraction of a left ureteral calcium oxalate stone; at that time there was a normal complete blood count, serum calcium and phosphorus and alkaline phosphatase; BUN of 21 mg/100 ml and uric acid of 6.0 mg/ml.

In January 1968 there was a transurethral prostatic resection; at that time the complete blood count, chest roentgenogram and ECG were normal; BUN was 20, and 3 urine cultures showed E. coli. In the hospital again Feb. 1–3, 1968, he passed 2 right ureteral calcium oxalate stones spontaneously, and had a normal serum calcium and uric acid of 7.2 mg/ml. As expected, his urine was found to contain white and red cell clumps.

Physical examination upon the last admission, Feb. 26, 1968, found a middle-aged man in severe pain but with normal temperature and pulse of 80 and regular. There was nothing of diagnostic significance except a very tender right upper quadrant; bowel sounds present and no rebound tenderness. Upon determination of a normal hemoglobin and hematocrit, white blood cell count of 12,000, fasting blood sugar of 193 mg/100 ml and a serum amylase of 1200, the clinical impression was cholecystitis with pancreatitis. On Feb. 27 the temperature rose to 102.6 F and intravenous cephalothin (Keflin) was started; blood taken on this day grew out cultures of A. aerogenes, E. coli, and Strep. viridans; serum amylase was 1005, calcium 8.9, bilirubin normal. On Feb. 28, there was a hypotensive episode treated with plasma and electrolyte solutions. Ampicillin (Polycillin) and regular insulin were begun; there were 10.2 units of serum lipase. On Feb. 29 the abdomen was silent, the patient was icteric and hallucinating, with a continuing febrile course, blood sugar still elevated, bilirubin rising and serum calcium falling.

There was little change until March 6 when there was a gastrointestinal hemorrhage which was treated with whole blood, fresh-frozen plasma, antacids, and vitamin K. Bleeding continued during the next 3 days, during which he was transfused and had multiple metabolic and electrolyte problems.

On March 10 he was found at surgery to have multiple gastric ulcers, acute noncalculous gangrenous cholecystitis, subacute pancreatitis, and right subhepatic abscess. Partial gastric resection was performed, along with retrocolic gastrojejunostomy, drainage of a subhepatic abscess, and cholecystostomy. Postoperative shock, not believed to be hemorrhagic, was combatted with hydrocortisone (Solu-Cortef), which he continued to receive for the next 9 days.

Pulmonary function studies on March 11, there being some dyspnea, showed hypoxia without pCO_2 elevation, which was attributed to regional hypoventilation. At this time the coagulation panel was normal except for a prothrombin time of 42% and a platelet count of 67,000. On March 12 there was a second massive gastrointestinal hemorrhage and the patient was again taken to surgery, at which time a near-total gastrectomy was performed with retrocolic re-anastomosis. An esophageal bleeding area noted at this time was oversewn and Gelfoam applied.

On March 13 the patient was started on the Bird respirator; an ECG at this time showed sinus tachycardia only, but on March 14 when the respirator was discontinued and he was extubated, the onset of congestive heart failure was noted and use of digitalis, aminophyllin and meralluride (Mercuhydrin) was begun.

On March 15 an ECG revealed atrial fibrillation with a ventricular rate of 140, frequent premature ventricular contractions, abnormal ST and T waves; digitalis intoxication was diagnosed and the drug was withheld for several days. The patient developed generalized peritonitis during the ensuing days, probably because of faulty drainage. He was taken to surgery again on March 27 and multiple abscesses within the abdomen were drained. New drains were inserted and the wound disruption was repaired. The endotracheal tube was left in postoperatively and use of the Air Shields respirator was begun. Ampicillin administration was stopped and chloramphenicol (Chloromycetin) begun.

On March 28 there was an episode of vomiting and bile-stained material was suctioned from the endotracheal tube. X-ray studies were not considered to show aspiration pneumonitis at this time, but the patient was deteriorating. On March 30 the coagulation panel was normal except for a platelet count of 37,000. Fresh frozen plasma and fresh whole blood were given. On March 31 the condition was considered terminal, and he died on April 1.

During the hospitalization period, 17 units of regular plasma, 13 units of fresh frozen plasma, 38 units of whole blood, and 3 units of fresh whole blood had been given.

Dr. Franke: Thank you, Doctor Paust. Are there contributory x-ray studies?

Dr. Donald Shaw (Resident in Radiology): We have a large number of films certainly, but nothing really helpful. In the cholecystostomy tube cholangiogram of March 20 (Fig 1) we see the gallbladder filled but are unable to determine anything of a specific nature; there is visualized what may be the beginning of the cystic duct, but we have no explanation for this. On March 10 you can see (Fig 2) there was probably an effusion present with a lot of atelectasis in both lung bases; he later developed an infiltrate in the left base that cleared before death.

Dr. Franke: Doctor Chamberlain, this was your patient. Do you wish to discuss the case now?

Dr. John O. Chamberlain: This situation can really prove to be a nightmarish one, as was certainly exemplified in the present instance. The patient had symptomatic cholecystitis and yet we could not substantiate the diagnosis objectively. Many of us have been trained in the dictum, which our own experience has seemed to support, that operation in the absence of objective evidence of the presence of stones should be only very reluctantly undertaken. And yet in 5% to 10% of cases of acute or chronic gallbladder disease there are no stones, and the surgical experience is not always bad.

I recall the case of an 80-year-old man who complained of dyspepsia in 1957–58, in whom the gallbladder x-ray studies were normal, but in whom nonvisualization of the viscus was demonstrated 2 years later. Because of his age and the fact that dietary adjustment and the use of antispasmodics fairly well controlled the symptoms, surgery was not suggested. After 2 more years, symptoms recurred and he became jaundiced, and at surgery a shrivelled, hard and adherent gallbladder with scarring about the ducts was found. Gross and histologic study disclosed acute and chronic cholecystitis without stones. The patient is still alive, asymptomatic, and working at the age of 86.

Another patient of advanced age, seen at about this same time, complained of dyspepsia, periodic upper abdominal distress, and symptoms of hiatus hernia, which was demonstrated by x-ray studies. The gallbladder was functioning normally at this time, but 2 days after a simple mastectomy 2 years later she developed acute upper abdominal pain and jaundice. Upon surgical exploration she was found to have an acute gangrenous gallbladder, again without stones. Many authors have referred to the high incidence of alithiasic cholecystitis in the postoperative period. Children comprise another group in which there is a relatively high incidence.

Another case of this same sort, but fortunately less severe than those I have cited or the one with which we are dealing this morning, occurred a few months ago in a 30-year-old resident here in this hospital.

One is simply obliged to say that the exact etiology of this type of gallbladder disease is unknown, although there are numerous speculations. Infection must be considered of course, since about 60% of all gallbladders contain organisms at the time of operation. Bile stasis is also thought to be important. Indeed this had to be considered in our case this morning, for when Doctor Boulanger and I stood at the necropsy table we saw a thick, viscid cast of the gallbladder's lumen with very little liquid bile—of course this was after there had been tube drainage and numerous other complications, but stasis might nevertheless have played a causative role.

Many observers feel that partial or even complete cystic duct obstruction is responsible for the pathology. But evaluation of cystic duct patency is sometimes difficult to accomplish. Of course tumors, even very small ones, may be causative, and they can be overlooked for long periods. Chemical or toxic insult to the gallbladder is also possible, and some men feel that refluxing pancreatic juice may be the causative agent. It is necessary to point out, however, in connection with the latter proposal, that the presence of pancreatic enzymes within the gallbladder is common because the pressure within the pancreatic system is always higher than that within the biliary tract. And then there may be allergic factors and, in the elderly particularly, vascular problems with compression of the cystic duct or actual thrombosis and infarction.

These 4 cases that I have dealt with, including the one we are considering this morning, were not conclusively diagnosed at any time during the months or years preceding exploration. Clearly we lack specific diagnostic aids. In a few centers some credence is still placed in the findings produced by differential duodenal drainage: intubation and collection of the bile before and after administration of concentrated magnesium sulfate solution for its cholagogic action—the so-called A bile is said to be that from the common duct, the B bile from the gallbladder and the C bile from the biliary radicles. The amount of these 3 biles, and the presence in them of epithelial cells, enzymes and evidences of infection is felt to be helpful in experienced hands.

Certainly the most usual practice is to hope for help from cholecystography. Most of us feel that if the result of such study reveals perfectly normal conditions, this entity has been excluded—meaning by that a gallbladder of normal size and shape, with good concentration and without abnormal shadows, with a fasting volume of 27–37 ml, with distinct contraction at a normal rate after a fatty meal (approximately 50% empty in 15 minutes and 75% empty in 60 minutes).

Dr. Franke: Doctor O'Neill, what is thought of the differential (A, B, C) bile test in gastroenterological circles?

Fig. 1

Dr. Philip B. O'Neill: It is believed that very little diagnostic help is to be obtained from resort to this measure.

Dr. Franke: Doctor Weber, would you kindly discuss the matter from the roentgenologic standpoint?

Dr. John C. Weber (Department of Radiology): Oral cholecystography is reputed to be 95% accurate, but to achieve this at least one meal before the trial should contain fat to empty the gallbladder so that it can receive the contrast-laden bile. It is a very common error to have patients who are sensitive to fats sent in to us on strict nonfat diets with request for immediate study. But with a properly prepared patient, in our experience a nonvisualization, or poor visualization, or visualization with fixed filling defect can be as significant as finding cholelithiasis. Most of the fixed filling defects, whether solitary or multiple, reflect cholesterol polyps. In general, if we diagnose such a polyp and the patient is asymptomatic, we feel it safe to have him followed clinically with repeat cholecystograms at intervals. If there is poor or nonvisualization, or a poor contraction following a fatty meal, it is probably advisable to repeat the examination. Nothing is gained by doubling the dose on this second trial. The contrast medium must be combined with a protein in the liver in order to be excreted through the biliary media, and the liver is limited in its ability to form this combination; increasing dosage of the material is likely to produce nausea, vomiting, and diarrhea and no cholecytographic advantage.

Fig. 2

One cause of nonvisualization is failure of the patient actually to take the contrast medium. Another, and amusing cause, is that he has already had a cholecystectomy when we are asked to examine him! An uncommon one is an anomolous position of the gallbladder, which may be found in the left side of the abdomen; it is our practice here to take a 14 x 17 picture, which covers the entire abdomen, if we fail to see a gallbladder on an 8 x 10 film. Any one of the severe liver or small bowel diseases can produce a poor or nonfunctioning gallbladder; obstructive jaundice from any cause, a stone in the cystic duct, gallbladder stasis, or failure to empty the viscus before giving the contrast medium.

When looking for stones in the cystic or common ducts in an individual who does not adequately concentrate the medium in the gallbladder, one can use the four-day telepaque technic: give a routine dose of telepaque daily for 4 days while maintaining the patient on a low-fat diet, and then take the picture on the fifth day; the contrast medium adheres to the stones on a nonexcretory basis independently of gallbladder function under these circumstances.

Dr. Franke: Thank you, Doctor Weber. Doctor Boulanger will discuss the surgical aspects of this case and of the subject in general.

Dr. Wayne J. Boulanger: None of us felt that the patient would be found to have a normal gallbladder at operation. He would have been admitted for routine cholecystectomy prior to this acute attack except for the recurrent urinary tract problems. Finally, his employer had suggested that he take a long vacation, possibly in February or March, and then come in for the elective surgery. The acute attack in February upset this schedule.

Surgeons are caught on the two horns of a dilemma in these cases: by the patients with symptoms and by the tissue committees. Perhaps it is the tissue committees that have kept so many of these gallbladders intact over the years. Reviewing the subject at their institution, the New York Hospital, Glenn and Mannix *(Ann. Surg.* 144:670, 1956) found that 135 of 3,110 gallbladders had been removed for chronic acalculous cholecystitis, a percentage of about 4.3; the tissue committee read 91 of these cases as chronic, 9 as cholesterolosis, and only 20 as normal. I think that any competent pathologist can legitimately diagnose "chronic cholecystitis," but whether the chronic inflammatory cells and changes in the mucous membranes in these gallbladders are provocative of symptoms is another matter. One must remember also that there is a certain mortality associated with cholecystectomy; there were 3 deaths in Glenn's 135 cases, a mortality of about 2%. Furthermore, these patients may have other maladies—pancreatitis, hepatitis, and the like—that may only be worsened by the surgery. In Glenn's series the results were said to have been good in 64.4% of cases, fair in 11.6%, and poor in 24%.

When you find no stones at operation, do you take out the gallbladder? Sometimes if you empty the viscus you will find thickening or obstruction in the neck, which had been obscured when there was distention with bile. Thickening and adhesions on the surface of the gallbladder should be looked for also. Glenn concluded that removal is perhaps not wise if none of these things can be found. There was also an illustrative series reported from the Cleveland Clinic by Hoerr (S. O. Hoerr and J. B. Hazard, *Am. J. Surg.* 111:47, 1966). In 14 cases in which no stones had been found when the gallbladder was removed, obstruction had been found in 6, carcinoma in 3, fibrotic stenosis in 1, vascular anomalies in 2; and there had been complicating pancreatitis in 5 of these cases and other things in some of them too.

In a series of 12 cases reported from Boston by Munster (A. M. Munster and J. R. Brown, *Am. J. Surg.* 113:730, 1967) there had been the following cholecystographic findings: normal, 3; nonvisualization, 3; large stone, 1; filling defect, 1; filling but no emptying, 1; poor function, 1; no visualization on intravenous cholangiography, 1. At operation on these 12 patients, the 3 gallbladders that had been declared normal upon x-ray examination, and 1 of those that had been declared nonfunctioning, were considered to be instances of mild chronic cholecystitis. Two of these 4 patients are still having symptoms and 2 are lost to follow-up. I suspect that the latter 2 have gone to another physician and are still symptomatic. The incidence of pancreatitis in this series was quite low—2 cases—since at least some authorities place this figure at 50%. The Boston group concluded that a normal looking gallbladder should probably not be removed, but one should be careful not to miss kinking, pancreatitis, collagen disease, or infections such as hepatitis and even appendicitis.

It is my observation that in general—the present case is one of the exceptions—the people with biliary tract disease without stones do not have as much discomfort as those who have stones. Perhaps they are also people who are a little bit more sensitive; they have a lot of gas and bloating and vague dyspepsia but not so often the classical subcostal pain radiating around into the back up between the shoulder blades. I do not believe that repeating the x-ray studies over and over is helpful. But I also believe that if there is no cholecystographic evidence of involvement, we should not operate. However, like all good rules, this one can be broken by a case like the one we are dealing with this morning.

I think that if we had operated on this man at once when he came in, he would be alive today. Pancreatitis is considered by many observers to be a deterrent to emergency operation, and yet in the past couple of years I have several times operated upon individuals for other reasons, being unaware of the pancreatitis, without dire postoperative results attributable to the pancreatitis. The cast of this man's gallbladder, which Doctor Chamberlain referred to, was the cause of his death. When, at the operation to control the gastrointestinal bleeding, I opened the gallbladder to put in the de Pezzer catheter, the mucous membrane had not sloughed and I could only remove it partially; I put in the catheter and brought it out through a separate stab wound, drained the subhepatic abscess, and finished my gastric resection and came out. But it developed that a tag of the gallbladder mucosa that had necessarily been left in kept flopping up against the holes in the catheter to render drainage inadequate. The gallbladder contents began trickling out around the tube—and that is what caused the patient's peritonitis, recurring abscesses, and death. At the time of the second operation, for the near-total gastric resection, the man's precarious condition precluded the doing of anything definitive regarding the gallbladder; and this was the situation at the third operation also.

A Physician: Doctor Boulanger, you allow yourself a 25% margin on appendectomies, why not be kinder to yourself on gallbladders?

Dr. Boulanger: The complication and mortality rates are the answer to that. At the New York Hospital there were 3 deaths in 135 cases; that is a little bit too high.

Dr. Philip H. Seefeld (Chief of Surgery): Our cholecystectomy mortality here, in a study made some years ago, was 3%.

Dr. Boulanger: Three percent; so you can't allow yourself the same latitude that you can with a normal appendix. I cannot recall a single case in this hospital's records in which removal of a normal appendix resulted in death.

A Physician: On the other hand, the risk of being involved subsequently in a serious situation is great in both cases, and since the gallbladders generally occur in older patients, probably the risk of missing one of them is more likely to lead to dire consequences than missing an appendix.

Dr. Boulanger: This is good reasoning, and certainly a case like this one today makes us review our thinking.

A Physician: I think the association of right upper quadrant pain with gallbladder disease does not necessarily cover all cases. I can recall 3 cases from my practice in which the pain was epigastric and yet these patients all proved ultimately to have small common duct stones.

Dr. Seefeld: About 6% of people with gallstones have pain on the left side, actually over the left hypochondrium. Preoperative diagnosis may be extremely difficult, although early operation will undoubtedly save some lives. There are many disputable points in biliary disease. For example, it is said that there is infection of the gallbladder at the time of surgery in more than 50% of instances, but the mere ability to culture organisms from a viscus, which is what these figures are based upon, establishes nothing more than that bacteria are there and not that there is infection in the usual sense in which we consider it a clinical entity.

Were any stones found in this patient's pancreas?

Dr. Boulanger: No. And at autopsy Doctor Ritchie was unable to demonstrate obstruction anywhere in the biliary tree or in the pancreas. Explanation of the patient's jaundice is still not clear, although of course all the infections he had might have accounted for it.

A Physician: How often do we have a normally filling gallbladder without stones roentgenologically when stones are really present?

Dr. Weber: I am unaware of accurate and reliable large scale statistics, but in our own experience we find this the most accurate of our diagnoses. We probably have an overall average diagnostic error of 15%, but in these gallstone cases the figure is closer to 5%. A case in which there has been reported a normal gallbladder and then after a 2 or 3 year interval a gangrenous cholecystitis, has no meaning; of course you can develop acute cholecystitis in a much shorter period than this.

A Physician: Did I understand Doctor Chamberlain to say that jaundice is a manifestation of the noncalculous syndrome?

Dr. Chamberlain: I think the incidence of jaundice, often unexplained, in these people is around 15%.

Dr. Franke: We were taught as students that atropine should always be used with morphine or meperidine (Demerol) to prevent sphincter spasm. This is done routinely preoperatively, but it appears that the atropine is always omitted postoperatively. Could its inclusion prevent some of the complications we see?

Dr. Chamberlain: It has certainly been charged that the omission of atropine with the postoperative morphine or meperidine is responsible for the postoperative pancreatitis that occurs so often.

Dr. O'Neill: One question for Doctor Weber. Is tomography helpful in visualizing gallbladders that are not imaged by other methods?

Dr. Weber: At the Lahey Clinic, Wise *(Surg. Clin. N. Am.* 44:731, 1964) is enthusiastic with respect to the information provided by the intravenous cholangiogram, reporting a fantastic 80% of visualizations. We are getting less than 50%, using about 50% more dye than he does. We use tomography (laminagraphy) on all our intravenous cholangiograms, and we believe it to be worth the effort.

Dr. Franke (summarizing): This morning we have developed the diagnostic and therapeutic difficulties encountered in the patient with a symptomatic functioning gallbladder. The internists, surgeons, and roentgenologists have all developed their viewpoints and discussed their experiences, and perhaps the subject, which is so difficult and frustrating, has thus been somewhat clarified in our minds. □

INTRAOSSEOUS LOWER EXTREMITY VENOGRAPHY

GENE P. WEGNER, MD; TIMOTHY T. FLAHERTY, MD; and ANDREW B. CRUMMY, MD, Madison, Wis: **Archives of Surgery** 98:105–110 (Jan) 1969

Utilization of lower extremity venography is often handicapped by technical problems created by the conditions one wishes to evaluate, such as edema, induration, or ulceration. Under such conditions percutaneous catheterization of a satisfactory vein may be impossible, surgical cannulation difficult, and the vein isolated may be unsatisfactory because of prior thrombosis.

The use of intraosseous venography affords a readily available injection site and perferential opacification of the deep venous system. The latter advantage obviating the often difficult need to distinguish between disease of the deep veins and incomplete shunting of contrast due to faulty tourniquet occlusion of the superficial venous system.

The only absolute contraindication to intraosseous venography is the presence of infection at the proposed area of bone puncture. Relative contraindications are coagulation dyscrasias and contrast agent idiosyncrasy. The presence of either acute or chronic thrombophlebitis is not a contraindication but rather a common indication.

Technique is discussed and various clinical applications are demonstrated including the use of lower extremity venography in the evaluation of intrapelvic and abdominal neoplasms, lymphedema, deep thrombophlebitis, and varicose vein disease. □

A Current Concept of Anesthesia for Obstetrical Delivery

By WILLIAM KREUL, M.D., Racine, Wisconsin

THE CONCEPT of minimal (just enough to do the job) anesthesia has been gaining favor for both surgical and obstetrical cases during the past twenty years. Coincidentally the use of nerve blocking anesthesia with or without inhalation supplement has grown in the United States as a whole.

In obstetrical circles generally, these trends have been accelerated by the shortage of anesthesia personnel. Obstetricians and anesthesiologists alike bemoan the shortage. Whether full obstetrical anesthesia coverage even in the large and medium-sized hospitals will ever be possible in a majority of situations is problematic. Whether such coverage is really necessary is open to question. When complete coverage is available, the tendency to use full unsupplemented general anesthesia is great. Such use is not in the best interests of the patient.

The obstetrician has a wide variety of drugs and kinds of drugs and techniques of administration of these drugs to resolve the analgesic demands of the obstetrical patient. During the first stage of labor, combinations of analgesics, hypnotics, and tranquilizers meet the requisites of the patient and prepare her for delivery. As the time of delivery nears, any deficit that exists in the control of pain and apprehension can be met by intravenously administered analgesic and tranquilizer drugs in appropriately reduced doses.

In all anesthesia administrations the necessity for improvisation exists. In spite of this, a preliminary plan of anesthesia is important. First, what is the history of prior experience with anesthesia both surgical and obstetrical? Secondly, historically what are the likely anesthetic requirements of this patient? With this knowledge on hand, what will satisfy the analgesic and anesthetic needs of this patient? Is sleep (anesthetic) or unconsciousness essential to her welfare?

A number of patients having had adequate analgesic, sedative, and tranquilizing support during labor will not require additional analgesia or anesthesia for delivery. When episiotomy or other surgical manipulation is not performed, self-administered methoxyflurane (Penthrane) may be helpful. In some others perineal infiltration with local anesthesia or a pudendal nerve block with or without self-administered methoxyflurane will suffice. Every obstetrician should be able to administer a pudendal nerve block just as he is able to do an episiotomy. An alternative procedure, especially applicable in the primipara, is a saddle spinal anesthesia administered in the sitting position at the level of the iliac crests or lower using glucose-weighted anesthetic solution. Local infiltration, pudendal and saddle spinal all may be supplemented by self-administered methoxyflurane (Penthrane). Supplementation also may be obtained with nitrous oxide or nitrous oxide and methoxyflurane or other inhalation anesthetic agents administered by an anesthetist or anesthesiologist. When associated or incidental pathological problems exist, the knowledge and skill of the anesthetist to supplement those of the obstetrician may be advantageous.

A tabulation of methods and combinations available to the obstetrician for use at the time of delivery highlights the variety.

1. Local infiltration anesthesia.
2. Local infiltration anesthesia plus self-administered methoxyflurane (Penthrane).
3. Local infiltration anesthesia plus inhalation anesthesia administered by anesthetist.
4. Pudendal nerve block anesthesia.
5. Pudendal nerve block anesthesia plus self-administered methoxyflurane.
6. Pudendal nerve block anesthesia plus inhalation anesthesia administered by anesthetist.
7. Saddle spinal anesthesia.
8. Saddle spinal anesthesia plus self-administered methoxyflurane.
9. Saddle spinal anesthesia plus inhalation anesthesia administered by anesthetist.
10. Self-administered methoxyflurane without nerve blocking anesthesia supplement.
11. Inhalation anesthesia administered by anesthetist without nerve blocking anesthesia supplement. □

Doctor Kreul is an Anesthesiologist.

MANUAL: BRACES—A PRIMER FOR NURSES

Basic information on braces, their use and care, is contained in the publication, **Braces: A Primer for Nurses,** just released by the American Rehabilitation Foundation, Minneapolis.

The 32-page manual is intended as a resource for nurses who work infrequently with patients who wear braces.

Priced at 85¢ per copy, the manual may be ordered from Publications, American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minn. 55404. □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Associate Professor of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

Medical Management of Parkinsonian Syndrome

By ARTHUR J. SYTKOWSKI, B.S., WALLACE H. M. CHUN, M.D. and RICHARD I. H. WANG, Ph.D., M.D., Milwaukee, Wisconsin

■ THERE ARE TWO DISTINCT reasons why a brief review of the management of parkinsonian syndrome is timely as well as appropriate. First is the recent wide publicity of the unusual efficacy of L-dopa for the treatment of Parkinson's disease. Second is the distinct change in the incidence of parkinsonian syndrome. In the past, idiopathic Parkinson's disease or paralysis agitans was the dominating cause of such a syndrome. With the advent of phenothiazines and nonphenothiazine antipsychotic drugs, the predominant incidence of parkinsonian syndrome has been drug induced.

It is not unusual for practicing physicians in emergency hospitals and wards to encounter acute manifestations of marked parkinsonian syndrome including akathisia, mask-like facies, shuffling or festinating gait, loss of associated movements, excessive dryness of mouth, and marked blurring of vision. Not infrequently a case of oculogyric crisis as well as dysphagia may be seen. Because the symptomatology of drug induced parkinsonian syndrome resembles closely that of paralysis agitans, management of this symptom complex can be considered together.

This review presents briefly the etiology, pathology, and current drug therapy of this syndrome.

Etiology

Since James Parkinson first described the symptom complex which bears his name, numerous causes of this complex have been found and simply recognized as the parkinsonian syndrome. The etiology of the parkinsonian syndrome listed in the order of decreasing importance and frequency is as follows: (1) drug induced, (2) idiopathic [paralysis agitans], (3) postencephalitic, (4) arteriosclerotic, (5) carbon monoxide and manganese poisoning, (6) head injuries, (7) cerebral tumors, and (8) hepatolenticular degeneration [Wilson's disease].

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Symptom Complex

The symptom complex which characterizes the parkinsonian syndrome includes: (1) poverty of movement [bradykinesia], (2) rigidity, and (3) tremor and nervousness. The fine movements of such patients are especially affected.[1] The rigidity is probably due to a generalized hypertonicity of the musculature. Passive movements are resisted, and voluntary movements are impaired by inappropriate relaxation of antagonistic muscles. The tremor is characteristically a resting tremor which is more pronounced with arms outstretched and almost invariably disappears during sleep. Other symptoms and signs are: akathisia, immobile facies, infrequent blinking of the eyes, festinating gait, loss of associated movements, retropulsion, propulsion, sialorrhea, seborrhea, blurred vision, and dryness of mouth. It should be emphasized that not every patient manifests all of the above symptomatology.

Pathology

The pathological findings in patients with drug-induced parkinsonian syndrome are currently unknown. The known pathologic changes are based upon findings from patients with other causes of this symptom complex. Depigmentation and degeneration of the pigmented nuclei of the brain, especially the substantia nigra and the locus caeruleus have been described.[2] Lewy bodies also have been found in the pigmented areas. It is not known, however, whether these findings represent the cause or the effect of the disease process.

Drug Therapy

Belladonna Alkaloids: The belladonna alkaloids, atropine and scopolamine, were used first in the treatment of paralysis agitans. Pharmacologic studies revealed that atropine acts as an inhibitor of the action of acetylcholine at the muscarinic sites, namely, the cardiac muscle, smooth muscle, and exocrine glands. Based on the work of previous investigators,[3-5] the central action of such compounds was recently delineated by Duvoisin.[6] He demonstrated that physostigmine, a cholinesterase inhibitor

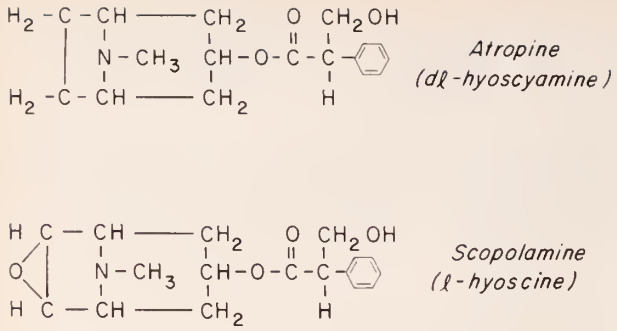

Fig. 1—The structural formulas of the belladonna alkaloids, atropine and scopolamine.

which can enter the central nervous system, antagonized the action of belladonna compounds. On the other hand, edrophonium, a cholinesterase inhibitor which cannot enter the central nervous system because of its quaternary nitrogen moiety, failed to antagonize the effect of belladonna alkaloids in alleviating the parkinsonian syndrome (Fig 1).

The disadvantages of the belladonna alkaloids are their peripheral actions which may lead to the development of side effects such as tachycardia, cycloplegia, constipation, urinary retention, xerostomia, anhidrosis, and xerophthalmia. Nevertheless some of the peripheral actions are in fact beneficial to patients with parkinsonian syndrome, for example, the alleviation of sialorrhea. However, belladonna alkaloids have been replaced exclusively by newer synthetic compounds which are claimed to have less peripheral activity.

Antihistamines: Antihistamines such as diphenhydramine (Benadryl) also have been demonstrated to be beneficial; however, the mechanism of action of these compounds in the treatment of parkinsonian syndrome is not known. The use of diphenhydramine, especially given parenterally to patients with cardiovascular disease and nervousness, is definitely preferable to that of the synthetic anticholinergic drugs, which invariably leads to tachycardia.

Orphenadrine (Disipal) has clinically insignificant antihistaminic activity and is mainly used for its anticholinergic action in the treatment of peptic ulcer under a different trade name preparation (Estomul). It has been erroneously quoted by authorities in the field of parkinsonism as an antihistamine.[7–9] Another commonly quoted antihistamine by the above authors is phenindiamine (Thephorin). It is such a weak antihistamine that its activity in the treatment of parkinsonian syndrome is doubtful.

Synthetic Anticholinergic Drugs: Trihexyphenidyl (Artane) was the first of the synthetic anticholinergic drugs used in the treatment of the parkinsonian syndrome. Its structural formula closely resembles that of diphenhydramine (Fig 2). Both its peripheral and central effects resemble those of the belladonna alkaloids.[10] Trihexyphenidyl appears effective in relieving rigidity, akathisia, and occasionally tremor. It

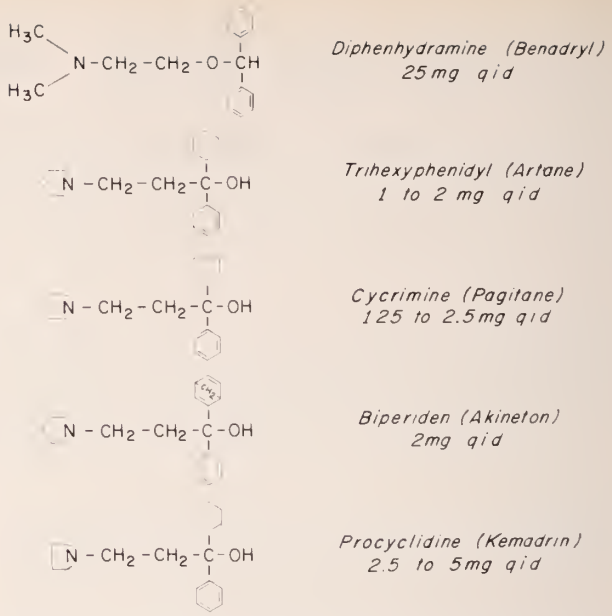

Fig. 2—The structural formulas and recommended initial daily doses of diphenhydramine, trihexyphenidyl, cycrimine, biperidin, and procyclidine.

also decreases sialorrhea. Like belladonna alkaloids at low doses such as 2 mg daily, it may have a sedative effect. On the other hand, at high doses such as 8 to 16 mg daily, it may increase nervousness due to stimulation of the central nervous system. Again, like atropine, it may precipitate or aggravate toxic psychosis.[11]

Other synthetic anticholinergic drugs have essentially similar actions like trihexyphenidyl. They are cycrimine (Pagitane), biperiden (Akineton), and procyclidine (Kemadrin). There is no good evidence preferring the use of one of these compounds over the others.[12–15] The recommended initial oral daily doses are indicated in Figure 2.

Benztropine mesylate (Cogentin) has an interesting structural formula in that it combines features of atropine and diphenhydramine (Benadryl). However, the drug is a synthetic anticholinergic and in spite of its popularity, reports indicate that it does not differ appreciably from atropine in any clinically significant manner.[12] Chlorphenoxamine (Phenoxene) is another anticholinergic drug occasionally used in the treatment of parkinsonian syndrome.

Ethopropazine (Parisdol) has a phenothiazine molecule and appears to have both anticholinergic activity as well as slight antihistaminic activity. There are conflicting reports concerning its ability to abolish tremor.[10,12,13]

Miscellaneous Drugs: Antidepressant drugs and other stimulants such as imipramine (Tofranil), dextroamphetamine, methylphenidate (Ritalin), desipramine, (Pertofrane, Norpramin), nortriptyline (Aventyl), amitriptyline (Elavil) have been used along with anticholinergic drugs with beneficial effect. However, these drugs are not commonly used in the treatment of drug induced parkinsonian syn-

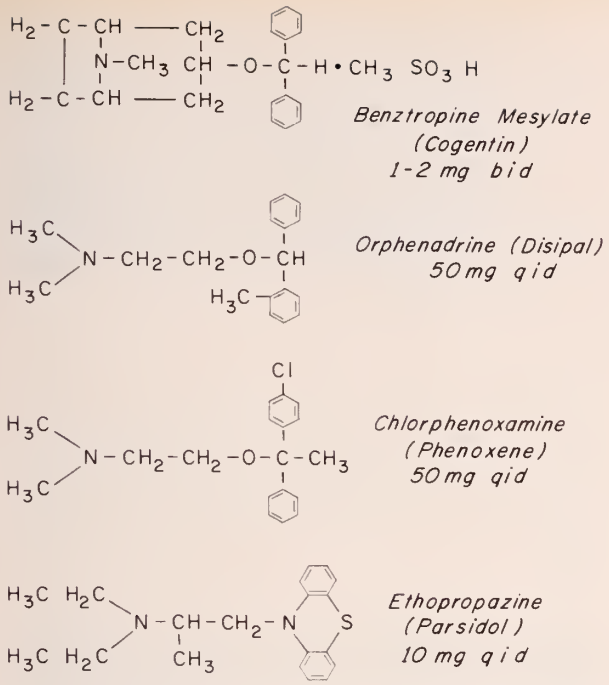

Fig. 3—The structural formulas and recommended initial daily doses of benztropine mesylate, orphenadrine, chlorphenoxamine, and ethopropazine.

drome; they are prescribed essentially for anergic patients with paralysis agitans.

L-*dopa:* L-dopa (levo-dihydroxyphenylalanine) has received considerable publicity in recent months. L-dopa is the active isomer of DL-dopa. The use of dopa is based upon the observation that dopamine (dihydroxyphenethylamine or hydroxytyramine), a catecholamine and a precursor of norepinephrine was found to be concentrated chiefly in the basal ganglia. In patients with Parkinson's disease there was a marked depletion of dopamine in the basal ganglia. Early clinical studies indicated that L-dopa crosses the blood-brain barrier and produces relief of the parkinsonian syndrome. Large doses of L-dopa orally (4–8 gm) showed improvement in patients with parkinsonism.[16,17]

Due to the lack of availability, only a few investigators in this country are treating paralysis agitans with this drug. Even though some patients are willing to accept the undesirable effects of L-dopa such as nausea, vomiting, orthostatic hypotension, and granulocytopenia, its value is inconclusive in view of conflicting reports.[17–19]

Summary

In conclusion, the most common cause of the parkinsonian syndrome today is secondary to antipsychotic medication. Fortunately, this is also the most easily controlled by the use of synthetic anticholinergics or antihistaminics. Since discontinuance or reduction of the dosage of antipsychotic drugs may precipitate mental symptoms, it is not unusual to

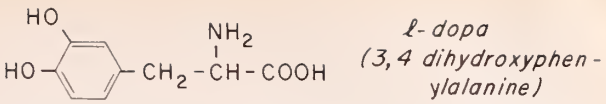

Fig. 4—The structural formula of 3,4-dihydroxyphenylalanine (L-dopa).

concomitantly prescribe anticholinergic drugs to counteract the side effects of the antipsychotic medication.

For the treatment of paralysis agitans or Parkinson's disease, therapy frequently is beneficial initially. Due either to early enthusiasm or to the progression of the chronic disease it is frequently difficult to control the parkinsonian manifestation in patients with paralysis agitans. Some of the doses of the anticholinergic drugs have to be increased rapidly so that side effects such as constipation, urinary retention, dryness of mouth, blurred vision, and so forth are common in these patients.

There is no convincing evidence that one synthetic anticholinergic is distinctly different from the other. Because one drug alone may fail to provide satisfactory relief, it may be beneficial for the physician to order other synthetic anticholinergic drugs. However, when two or more of the same group of drugs are used, their therapeutic value and side effects cannot be readily controlled and assessed. The use of L-dopa in the treatment of paralysis agitans is under intensive investigation at this time. It is premature to conclude its value or role in the drug therapy of parkinsonian syndrome.

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MECHANISM OF SPLIT CRANIAL SUTURES IN METASTATIC NEUROBLASTOMA

THOMAS L. CARTER, MD, TRYGVE O. GABRIELSEN, MD and MURRAY R. ABELL, MD, Madison General Hospital, Madison, Wis.: **Radiology** 91:467–470, 475 (Sept) 1968

Skull metastases and split cranial sutures frequently occur in patients with neuroblastoma. Ten autopsy proven cases with an undisputed diagnosis of neuroblastoma originating outside the skull are used to emphasize the pattern of cranial and intracranial metastases found at autopsy. Radiographic and clinical findings are correlated. Deposits of neuroblastoma involving the calvarium are usually continuous with the subperiosteal and extradural metastases, which may be very bulky. The dura mater seems to act as a barrier to deeper penetration by tumor. The brain is rarely, if ever, involved with neoplasm. The dural venous sinuses are ordinarily patent. It appears that the split cranial sutures act chiefly as a mechanism for accommodating bulky extradural metastases. An extensive review of the pertinent literature is included. □

CUTANEOUS MANIFESTATIONS OF THE SUPERIOR VENA CAVA SYNDROME

PRISCILLA SWANSON, MD et al, Marshfield Clinic, Marshfield, Wis.: **Arch Derm** 98:628–630 (Dec) 1968

The clinical appearance of patients with superior vena cava syndrome may resemble that of angioedema of the face, contact dermatitis, congestive heart failure, or allergic blepharitis. In addition a dilated band of blood vessels around the chest wall and gynecomastia may be present.

Two such patients have presented with marked erythema and edema of the face and eyelids, phlebectasia of the chest wall and gynecomastia. Clinically, the picture of engorgement suggested obstruction of the superior vena cava. Chest x-ray films revealed a primary bronchogenic carcinoma in each case.

The syndrome also may be caused by lymphomas, posterior mediastinal (neurogenic) tumors, substernal goiter, mediastinitis, thymic tumors, dermoid cyst, mediastinal fibrosis (secondary to radiation or granulomas, such as histoplasmosis or TB), aortic aneurysm, A-V shunt, mitral stenosis, pericarditis, superior vena caval thrombosis, mediastinal hematoma or osteomyelitis of the clavicle. However, by far the commonest etiology is primary or secondary intrathoracic malignancy, chiefly bronchogenic carcinoma. □

PSEUDOCOARCTATION OF THE AORTA

IVAN L. SHAPIRO, MD, Marquette School of Medicine, Milwaukee, Wis.: **Arch Intern Med** 122:345–348 (Oct) 1968

Pseudocoarctation of the aorta, a rare congenital malformation resulting in elongation of the aortic arch and kinking at the ligamentum arteriosum, is described in two patients.

One patient had an associated anomaly, congenital aortic stenosis, with a systolic transvalvular gradient of 40 mm Hg, and an elevated left ventricular end-diastolic pressure (25 mm Hg). There was, however, no gradient across the kinked segment. He had previously undergone ligation of a patent ductus arteriosus, an anomaly heretofore unreported in conjunction with pseudocoarctation.

The other patient had previously undergone thoracotomy for a left superior mediastinal mass, found at operation to be pseudocoarctation. Resection was not done. Left ventricular end-diastolic pressure was elevated (24 mm Hg), possibly due to his hypertension. However, a 10 mm Hg systolic gradient with delayed pressure rise distally was demonstrated across his kinked segment.

It is emphasized that pseudocoarctation of the aorta should be ruled out by aortography in patients presenting with left superior mediastinal masses. Associated cardiovascular defects should be sought. A mild pressure gradient across the kinked segment may be present, but its relationship to left ventricular dysfunction is not certain. □

IF YOU DO A GOOD enough screening job you may get people in your employ who are perfectly normal. But you will have screened out people who discover things like nylon. . . . Dr. Frederick Dershimer, retired psychiatrist, E. I. duPont de Nemours & Company. □

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President's Message to the House of Delegates

By ROBERT E. CALLAN, M.D.

Milwaukee, Wisconsin

■ DURING THE PAST YEAR as president-elect, it has been my privilege and pleasant duty to serve under our president, and my fine friend, Dr. William D. James. In addition to assisting and acting for him when he was busy with society affairs elsewhere, I tried to the best of my capacity to crystalize my understanding of the needs of the medical profession in Wisconsin.

It would serve little purpose at this time to list the many problems facing the medical profession and society in the health area. We all know these problems are many, complicated, serious, and deserving of in-depth consideration. There are no easy solutions. As Doctor James has pointed out, our members have been active during the past year, in cooperation with allied health professions and consumers, in an earnest effort to provide access to the highest quality of medical care to all of our citizens at a reasonable price. We shall continue to meet these challenges with the dedication and objectivity that is the hallmark of a true physician and in the light of the philosophical and ultimate objectives of our State Medical Society, namely, "to make the Medical Society more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life."

Presented before the House of Delegates at the 128th Annual Meeting of the State Medical Society, May 12, 1969, Milwaukee.

Perhaps it was our very preoccupation with our primary traditional responsibilities in medicine, patient care, in an era of manpower shortage that precipitated and fostered a new kind of "health expert," usually self appointed, vocal and articulate, and seemingly omniscient, but strangely lacking in actual medical experience with the final objective of all medicine, the patient. We will be forced from now on to direct more of our efforts and attention to the health problems of society as a whole, taking time from our more traditional roles as patient-oriented practicing physicians, as teachers and as researchers. This new direction entails considerable sacrifice for the physician and in some instances it is like moving into a new and uncomfortable world, requiring a new language, great patience, flexibility, an open mind, and a willingness to participate in a community effort.

Individually and collectively we are admirably suited to offer considered advice, direction and guidance to efforts directed at solving society's health dilemmas as we can contribute the priceless ingredient for successful solutions: actual first hand experience in medicine. Our law makers are now listening more attentively to the opinions of physicians that actually take care of sick people, to the opinions of the teachers that are actually preparing our future physicians, to the opinions of actively engaged medical researchers, and to the physicians in public health that deal with people and not with statistics. The secret of patient care, of course, is caring for the patient. Let us never forget it.

Our Work Week of Health again this year will be directed to the younger generation. This is as it should be since in 1970 more than half of the population of the United States will be in their early twenties, or less. We cannot, however, slight our aging patients nor can we accept their indiscriminate banishment to bigger, better but more impersonal nursing and custodial institutions as a solution. This is hardly in keeping with our Principles of Ethics which reminds us that the principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. A thorough study of senescence, physiologic and pathologic, its implications and complications, its physical, emotional, and socio-economic aspects needs to be undertaken by our Society, in cooperation with other experts in this area.

While we have in our State Medical Society an organizational structure and staff well suited to our present needs, we need to increase our efforts to develop programs directed to the changing needs of the physician and the medical profession. We especially need, in common with most organizations, a better informed and more active membership, so that our county medical societies, our House of Delegates, our committees and commissions may function with maximum efficiency and effectiveness. We must constantly fight indifference, so prevalent in these times. "Indifference," the English author Ouida warns, "is the invincible giant of the world," while Emerson counsels "nothing great was ever achieved without enthusiasm."

In closing I feel it urgent to remind our members that while we, as physicians, are primarily concerned with our patients' medical needs, we must in these inflationary times particularly, act as wise conservators of health resources wherever possible, consistent with sound patient care. The rising costs of quality medical care could possibly price it off the market for many people. The individual physician is in the best possible position to help his patient make the most of whatever economic resources are available to him—whether they be in the form of cash, insurance, prepayment, or taxes.

Finally, it is with pragmatic idealism that I look ahead to my term as president. With the active guidance of our policy-making House of Delegates and our board of trustees, our Council, I am confident the State Medical Society will continue to give its best in the service of Humanity. □

UNIVERSITY OF WISCONSIN RESEARCH

Discover New Method of Detecting Inborn Error of Metabolism

University of Wisconsin doctors have made what they believe is the first intrauterine diagnosis of a metabolic disorder that causes birth defects, the Lesch–Nyhan syndrome.

Using cultures of amniotic fluid Drs. Gloria E. Sarto, Robert I. DeMars, Jeannette S. Felix, and Paul P. D. Benke diagnosed a case of Lesch–Nyhan syndrome 18 weeks before birth at UW Hospitals.

The four Wisconsin medical researchers believe this is the first time a diagnosis of this inborn error of metabolism has been made with cells cultured from amniotic fluid.

Amniotic fluid cell cultures also are being used to determine the sex of a fetus in cases where there is an increased risk of certain diseases for a male infant, and to diagnose chromosome abnormalities that will result in birth defects.

The Wisconsin doctors used a radioactive labeling technique in their diagnosis of Lesch–Nyhan syndrome.

It is now possible, the researchers explain, to use intrauterine cell cultures in pregnancies in which there is a family history of birth defects in either parent. Ultimately, it is hoped that if this test accurately indicates that an infant is to be born with a serious birth defect, physicians could then institute appropriate therapy while the infant is still in the uterus.

The UW research on intrauterine diagnosis is sponsored by the National Institutes of Health. □

When Labor is Prolonged

By FREDERICK J. HOFMEISTER, M.D., Milwaukee, Wisconsin

POTENTIAL HAZARDS exist inherent in every labor, but "when labor is prolonged" these hazards are compounded.

Friedman[1] stresses the value of careful observation of progressive cervical dilatation and descent of the fetus during labor for the purpose of detecting abnormalities of labor as they arise. He indicates that because of faulty monitoring of all aspects of labor over 20 hours, 62% of abnormal labors of this duration in nullipara are erroneously called normal and 100% of abnormal labors in multipara are called normal.

Labor with significant repetitive contractions continuing beyond 20 hours is considered prolonged. It is essential to realize that not all rhythmic contractions occurring at or near term are true labor contractions. Patients enter the hospital stating that contractions have existed for hours and because of these may expect rapid progress of labor and delivery. Examination will reveal a long, thick and undilated cervix. The described contractions have been the socalled "false labor" Braxton–Hicks contractions. If these are added to the true labor time, an erroneous diagnosis of prolonged labor will be made.

Friedman states that when the patient indicates the existence of contractions and the uterus becomes firm to palpation but progress is lacking, "the nicest obstetrical judgment is required, for one of the commonest errors is to treat a patient for uterine inertia when she is not yet in labor." True labor can only be considered present when rhythmic contractions result in progressive effacement and dilatation of the cervix, progressive descent of the fetus and ultimately the delivery of the infant.

When labor approaches 24 hours, potential fetal hazards increase. Anoxia is a hazard which when unsuspected and undetected can result in a retarded infant. Labor of 30 hours increases this problem and adds additional problems related to the mother. Massive hemorrhage in the immediate postpartum period due either to the trauma of labor and delivery or an atonic uterus can cause pituitary neurosis and associated menstrual disturbances with resultant infertility. Hemorrhage can lead to tissue devitalization which then results in infection.

A revised and updated version of Doctor Hofmeister's article, "After 20 Hours of Continuous Labor," that appeared in the July 1962 issue of the **Wisconsin Medical Journal**, prepared at the request of the Maternal Mortality Study Committee of the State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments.

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Ideally, modern sophisticated electronic monitoring devices which will record intensity of labor pains, rate of fetal heart and the relation of contractions to the fetal heart rate are anticipated as one solution to avoiding fetal anoxia, damage, and stillbirth. Actually, accurate monitoring by auscultation as described by Caldeyro–Barcia will, if intelligently used, warn against impending disaster. In his presentation before the Milwaukee Gynecological Society, Feb. 3, 1969, Caldeyro–Barcia indicated that simultaneous decrease of the fetal heart rate with increased intensity of contractions was a normal phenomenon. This decrease rapidly returns to normal during the relaxation phase of the uterus. He warned that if auscultation is performed immediately preceding, through and following a contraction, hazard is indicated when the fetal heart rate decreases during the period of uterine relaxation which immediately follows the height of a contraction. Unless the administration of a uterine relaxant is possible, immediate termination of the pregnancy is essential. Attention is also directed to the great hazard of having the patient lie in the supine position for prolonged periods of time. This can have a detrimental effect on maternal blood pressure, uterine and placental blood flow, and consequently on the fetal status. Placing the patient on her side is usually followed by a prompt return of maternal blood pressure to normal and a return of the fetal heart rate to normal. Any labor requires this alert monitoring but, when labor exceeds 20 hours, a systematic inventory of the historical aspects of the labor and an evaluation with increased, accurate monitoring is mandatory.

During 1968, there were 1482 deliveries at Lutheran Hospital of Milwaukee. Sixty-five labors were, by definition, prolonged; an incidence of 4.3%. The average national incidence of prolonged labor is accepted as occurring between 1.5% and 5% of deliveries. Prolonged labor ended in Cesarean section 11 times, an incidence of 16.7% of the 65, as compared to an overall section rate of 4.5% for the 1482 deliveries. There were no maternal deaths. The impact on the 65 infants, victims of the prolonged labors, will be completely realized only if accurate pediatric and psychological monitoring is possible through elementary and secondary schools.

It is assumed that in 1969 adequate, high-standard, antepartum care is available to all who are motivated to request it. This adequate care will, by accurate evaluation, detect abnormalities of lie, position, presentation, structure of the fetus, architecture of the maternal bony pelvis and the presence of obstructing tumors. It has been reported[2] that from 13% to 57.5% of prolonged labors are caused by these detectable abnormalities. When abnormalities

cannot be detected during antepartum care, additional causes may exist and true labor may extend beyond 20 hours in the primigravida and 12 hours in the multigravida.

When labor reaches the 20-hour period, the time which is designated as the warning signal, what is the course? Certainly this does not mean the patient must be delivered because an arbitrary danger time has been reached. It does mean that if delivery is not imminent, the red flare of danger has been ignited indicating the necessity for a complete patient and progress reevaluation.

This reevaluation should be systematic. It should include a review of her complete labor record. The fluid intake and output of the patient should be calculated and the state of hydration noted. Fluids adequate to establish hydration and nutrition should be given. The character of the contractions should be reevaluated. It is well to note that 20 hours of 10-minute contractions are less significant than 20 hours of 3-minute contractions. The amount of sedation which has been administered should be determined. A careful, sterile vaginal examination should be done to detect problems of position or presentation and definitely establish the degree of dilatation and effacement. The character, rate and quality of the fetal heart tones must be repeatedly checked. The manner in which they are checked can add valuable knowledge. The admonition of Caldeyro-Barcia as noted in the beginning of this presentation should be reviewed. Hazards exist when a significant decrease in the fetal heart rate exists during the period of uterine relaxation immediately following the peak intensity of a contraction. If the membranes are intact, amniotomy may be indicated. Ineffectual labors have converted to productive labors very shortly after membranes have been ruptured. No damage can be done if the presenting part is engaged and if the presentation is cephalic.

It may be that at this time, clinical indications point to the necessity of x-ray evaluation. X-ray films may reveal the illusive midplane contraction or a straight sacrum, or both. They may disclose malformation or disproportion or confirm abnormal position. The reevaluation of the patient will be incomplete unless the opinion of another physician, impartial and unrelated to the problem case, is requested. Consultation is necessary. It can be of great help. Consultation may result in an opinion to further adjust fluid balance, to rest the patient and later stimulate and reactivate labor with an intravenous drip of an oxytocic (Pitocin), or to actively intervene. Consultation may eliminate the confusion resulting from indecision, indecision resulting from pressure due to the physician's own commitments. These pressures or apparent obligations may result in the injudicious use of such procedures as version and extraction which, today, has only limited indications; Dührssen's incision, which can create lasting defects unless accurately made and repaired; and traumatic forceps applications and deliveries.

Beware of the hazards and recognize your responsibilities when oxytocics are used. Real dangers may exist for the primigravida and multigravida (especially elderly multigravidas) with the injurious administration of stimulation. Stimulation may result in rupture of the traumatized lower uterine segment. The patient's response to stimulation may be such that tetanic contractions will result. This creates great hazards to an infant and can also result in precipitous expulsion of fetus with resultant extensive vaginal, cervical and/or uterine lacerations. It is the physician's responsibility to be available for emergency or to have a designated professional representative available to cope with any emergency and to avoid the catastrophe which can result when oxytocics are administered.

Remember, statistics indicate that after 30 hours there is a progressive hazard to both mother and infant. Probably after 30 hours, we are stepping from prolonged labor to neglected labor. If reevaluation has been made at 20 hours, and progress has not been satisfactory after rest and hydration, Cesarean section is indicated. Antibiotics will have been started by 20 hours regardless of ruptured or intact membranes. It is recognized that after 12 hours of active labor, positive cultures can be obtained from the amniotic fluid even when membranes are intact and certainly when membranes have been ruptured during this period of time.

Accurate Care

With intelligent observation and accurate care, the result should be excellent. The time is at hand for us to recognize the necessity of an intelligent approach based on careful evaluation and to cast aside antiquated methods of obstetrical gymnastic procedures and obstetrical tricks for Cesarean section, when indicated. It is time to disregard some arbitrary statistical ceiling which has been established to regulate our judgment when confronted by the decision for Cesarean section. Poor results of Cesarean section for mother and infant will increase in direct proportion as length of labor increases beyond 30 hours. This should not mean that we are to set aside caution, policy, and indications for what some erroneously consider convenience. Sections still are associated with every hazard of major surgery. If they are performed when indicated, the overall section rate could, at times, rise beyond 5 or 5.5%. However, additional infants will be salvaged.

The pattern of a patient's future childbearing, indeed the question of whether she will ever conceive again, may depend upon the conduct of her labor and the memory of her delivery experience. Make it a gratifying experience.

Summary

An attempt has been made to indicate the necessity for persistent effort by the obstetrician to combat the entity of prolonged labor. This must start in the antepartum period by complete examination, evalu-

ation and care, and by instilling within the patient confidence in her physician with emphasis directed to the fact that the patient who is informed and has confidence will have a naturally decreased labor time. Although seemingly contradictory, I would admonish you that complacency on the part of the physician and/or the patient because of the tendency to emphasize naturalness must never be permitted to replace intelligent care by a physician well trained to observe, care for, and actively intervene with Cesarean section when necessary, instead of using antiquated obstetrical tricks. It must always be emphasized that the practice of obstetrics may suddenly necessitate major surgery and that, when least expected, complications may arise which may require surgical skill, or which may result during a fleeting short moment in the elimination of a life, in fact two lives, because of faulty judgment or the use of a faulty procedure.

Conclusion

1. Efforts to successfully combat prolonged labor must begin with the initial visit of patient to physician.

2. Thorough history and physical examination will reveal the complete status of patient and prepare the physician to combat any abnormalities. This thoroughness will also establish confidence and result in a relaxed patient.

3. At term: Patient and physician must be aware of the exact definition of labor, "rhythmic uterine contractions that result in progressive thinning and dilatation of cervix and the eventful delivery." "Labor must be recognized."

4. A standard of time limits must be established for normal labor versus prolonged labor. Twenty hours seems to be a logical dividing point between normal labor and prolonged labor. However, a labor of any duration, when abnormalities exist, may be prolonged.

5. What should 20 hours mean?
   - A. IT DOES NOT mean delivery should occur.
   - B. IT DOES MEAN an inventory must be taken.

6. What is this inventory? Evaluation of:
   - A. Status of fetal heart tones and notation of any rate variation in relation to uterine contractions.
   - B. Type, duration and interval of uterine contractions.
   - C. Medication, type, and dosage.
   - D. Hydration.
   - E. Status of bladder.
   - F. Antibiotic coverage in labors extending between 12 and 20 hours as indicated.
   - G. Findings of vaginal examination.
   - H. Status of membranes—ruptured or intact?
   - I. X-ray evaluation. This is a most valuable time for x-ray examination.
   - J. CONSULTATION!

7. Method of delivery must depend upon reevaluation.
   - A. Rest, hydration and later stimulation may be the answer to vaginal delivery.
   - B. Reevaluation may indicate Cesarean section to be the method of choice.

REMEMBER—Every hour over 24 hours takes an increased fetal toll. After 30 hours, prolonged labor often can be considered neglected labor with an increasing maternal toll added to the increased fetal toll.

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Wisconsin's Comprehensive Mental Retardation Planning-Implementation Program

The State Medical Society has received a report of Wisconsin's Comprehensive Mental Retardation Planning-Implementation Program. The publication is one of a series of reports representing the collective thinking of many knowledgeable people in mental retardation in this state. Many of the recommendations found in the reports have already been implemented and others are in the process of being implemented.

The series of publications based upon this planning program include the resumé—"It's Up To You," the complete and final report—"Quiet Revolution: Wisconsin's Plan for the Mentally Retarded," and five original Task Force reports, which include Barriers to Service, Regional and Community Services, Fiscal and Legal Issues, Education and Rehabilitation, and Health Care. There is also a slide presentation based upon the various reports.

The reports and the slide presentation are all available upon request from the District Mental Hygiene Administrator or the State Department of Health and Social Services, Division of Mental Hygiene, Room 343, State Office Building, 1 West Wilson St., Madison, Wis. 53702. □

Prevention of Catheter Bacteriuria

By DAVID T. UEHLING, M.D., Madison, Wisconsin

■ BACTERIAL CONTAMINATION of the urinary bladder by catheterization has been widely criticized in the past years.[1–5] The possible lethal outcome of Gram-negative septicemia is well recognized.[3] Since the urethral catheter is necessary for urologic surgery, we have undertaken to see whether one type of catheter care could be practical for postoperative patients and could prevent the bacteriuria associated with an indwelling catheter.

Methods

A regimen of catheter care was designed to be easily understood and carried out by the nursing staff, to be inexpensive, and not to interfere with the postoperative care of the patient. No special type of catheters was employed. Triple lumen catheters as used by others to prevent catheter bacteriuria are not practical in urology where a larger outflow diameter is helpful for egress of clots.

Since one of the aims of the catheter-care regimen was to avoid catheter bacteriuria totally, no antibiotics were given orally, parentally, or into the lumen of the catheter. The catheter was placed following surgery, and thereafter the orders called for washing the junction of the catheter and the urethra twice daily with soap and water and wrapping this junction with moist Zephiran gauze. Catheters were not irrigated except when plugged with blood clots. When this was necessary, sterile gloves and sterile technique were used. Otherwise, the segments of tubing were not unhooked and the patient was ambulated and asked to carry his collection bag with him. The collection bags were emptied from the bottom so as to avoid touching connecting parts. Bags were emptied frequently so that possible bacteria in the bags could not ascend into the tubing. No preservatives were kept in the bags.

Urine cultures were obtained at the time of the operative procedure and at intervals in the postoperative period by needle aspiration of the distal catheter following swabbing it with alcohol and by the mid-stream technique following removal of the catheter. Following removal of the catheter and collection of urine by the clean mid-stream technique, over 100,000 colonies per millimeter were required before the colony count was thought to be significant. Any growth obtained from aspiration of drainage tubes was considered significant. Patients who had bacteriuria before surgery were managed in a similar fashion but were not included in this study.

Results

A representative group of 26 patients followed with this regimen is listed in Table 1. The first group consists of eight men having transurethral resection for benign prostatic hypertrophy, two women having transurethral resection of bladder tumors and one woman having transurethral resection of a ureterocele. All these patients had relatively short-term need for an indwelling catheter. One patient in this group was considered a catheter-care failure since the voided urine following removal of the catheter showed over 100,000 colonies of Proteus. The next group of nine patients all required open surgical procedures and none had significant colony counts following removal of urethral catheters. The remaining six patients were all children who required catheter placement other than in the urethra. Two catheter-care failures occurred in this group. One failure associated with hypospadius repair did not have significant bacteriuria until a voided urine was collected following removal of the suprapubic tube. One child with a bilateral ureteral reimplantation developed a positive culture of Pseudomonas from the right ureteral catheter emerging alongside a suprapubic tube despite the same care administered to all three drainage tubes. This child had had infection in the past, but had a sterile urine prior to reimplantation of significantly dilated ureters bilaterally.

Discussion

The regimen here described does not require special nursing care, expensive equipment, or interference with postoperative care. The urine from most bladder catheters can be kept free from significant infection in the immediate postoperative period. This is true in male and female patients and in a wide age range. The normal male can often void a completely sterile mid-stream specimen. This is not usually the case following indwelling catheterization. The urethritis associated with an indwelling urethral catheter results in the mid-stream voided specimen having bacteria present in insignificant numbers. Suprapubic and perineal urethrostomy tubes present no special problem. Patients undergoing renal transplantation represent a special situation in that they require immuno-suppressive drugs and any minor infection can be life-threatening. It was particularly gratifying that this regimen kept these patients free from urinary tract infection during the two days of catheter

From the Department of Surgery (Urology), University of Wisconsin Hospitals.

Presented in part at the Kidney Foundation of Wisconsin meeting, Madison, Oct. 11, 1968.

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TABLE 1—*Results of Catheter Care*

Age	Sex	Operation	Duration	Follow-up	Culture
66	M	TURP	4 days	Aerobacter	4,000 col ml
69	M	TURP	2 days	Staph.	1,000 col ml
63	M	TURP	4 days	Candida	50,000 col ml
52	M	TURP	2 days	Staph.	55,000 col ml
59	M	TURP	3 days	No growth	
68	M	TURP	3 days	Staph.	75,000 col ml
83	M	TURP	3 days	Proteus	100,000 col ml*
55	M	TURP	2 days	No growth	
56	F	TUR Bladder Tumor	2 days	E. coli	1,000 col ml
72	F	TUR Bladder Tumor	2 days	No growth	
27	F	TUR Ureterocele	2 days	No growth	
66	M	Exc. Urachal Cyst	2 days	No growth	
60	F	Cystourethropexy	7 days	No growth	
71	M	Prostatectomy	8 days	Enterococ.	75,000 col ml
55	M	Penectomy	4 days	Diph.	1,000 col ml
67	M	Ureterectomy	8 days	No growth	
33	M	Renal Transplant	2 days	No growth	
33	M	Renal Transplant	2 days	E. coli	10,000 col ml
34	M	Renal Transplant	2 days	Kleb.	5,000 col ml
5	M	Urethroplasty (SP tube)	12 days	No growth	
11	M	Urethroplasty (SP tube)	13 days	Staph.	100,000 col ml*
4	M	Urethroplasty (Perineal tube)	11 days	Proteus	10,000 col ml
7	M	Urethroplasty (SP tube)	14 days	Proteus	5,000 col ml
16	M	Urethroplasty (SP tube)	13 days	Enterococ. (from tube)	10,000 col ml*
6	M	Uret. Reimpl. (R. ureter) (L. ureter)	4 days	Pseud. (from tube)	75,000 col ml*

* = Failure.

drainage needed following reimplantation of the donor ureter into the recipient's bladder.

The results presented here are in marked contrast to Kass's findings that 95% of patients with open catheter drainage for four days developed significant bacterial infection in the urine.[1] The results largely agree with those presented by Kunin in his study of a closed drainage system similar to the one outlined. However, in Kunin's series, 82% of patients received systemic antibiotics which may promote emergence of resistant bacteria in the patients who were not kept free of bacteria by catheter care.[2] The emergence of resistant bacteria is also a complication of a regimen which employs bacterial irrigation of the bladder with antibiotics.[3] In view of the success of a regimen not employing any antibiotics, this complication seems unnecessary.

The three failures were possibly preventable. The elderly male who acquired significant infection following transurethral resection of the prostate required multiple irrigations of blood clots from the bladder in the immediate postoperative period and presumably proper care and time were not possible to prevent contamination. In the child who developed a significant infection following hypospadius repair, the suprapubic tube had been in place for 13 days and even diligent catheter care will not prevent catheter bacteriuria indefinitely.

No patient in this series developed clinically evident septicemia and no positive blood cultures were obtained. Most of the patients had minor temperature elevation in the immediate postoperative period, but none in this series were treated with antibiotics. While the treatment of Gram-negative septicemia has not improved dramatically and 50% of patients still succumb, the incidence of Gram-negative septicemia from the urinary tract can be markedly reduced by preventing catheter bacteriuria.[3] This is the principal reason for having a vigorous catheter-care regimen. Our study did not attempt to define the incidence of Gram-negative bacteremia or its consequences. Miller *et al* have shown that patients who have sterile urine do not develop bacteremia upon removal of the catheter, whereas those with urinary tract infection have a 50% chance of having a positive blood culture five minutes after catheter removal.[4]

This study does not attempt to prove that prevention of significant catheter bacteriuria reduces the number of long-term complications. Others have shown that prostatectomy patients do have fewer complications when the urine is sterile in the early postoperative period.[5]

Summary

The results of an uncomplicated catheter-care regimen are presented. Antibiotics which may induce emergence of resistant bacteria are not employed. The case of the method is outlined and causes for the failures noted. The prevention of septicemia and surgical complications are worthwhile benefits to be reaped from diligent catheter care. The concept that bacteriuria inevitably accompanies the indwelling catheter is not accurate. Further improvements in catheter-care regimens should even further reduce complications.

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Osteogenic Sarcoma of the Sternum

CASE REPORT

By ROBERT W. EDLAND, M.D., THOMAS J. MULLER, M.D.
and ROBERT O. JOHNSON, M.D., Madison, Wisconsin

■ PRIMARY OSTEOGENIC SARCOMA is not a common neoplasm. It has been estimated to occur with a frequency of about one case per 100,000 persons in the United States,[1] and about one case per 75,000 in Great Britain.[2] Osteogenic sarcoma of the sternum is an exceedingly rare lesion. The incidence is about 0.5% of all osteosarcomas[1, 3] and less than 20 reported cases can be detected in the literature. The following is an additional case report of a primary well differentiated osteoblastic osteogenic sarcoma of the gladiolus sterni.

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Case Presentation

The patient on presentation was a 30-year-old Caucasian woman who had enjoyed excellent health until May 1965, when she noted a small, hard, painless mass developing over her sternal area. By September the mass had enlarged significantly and the patient experienced chest pain on deep inspiration. In early November 1965, roentgenograms of the chest (Fig 1a, 1b) revealed an apparent neoplasm arising from the sternum and she was referred to University Hospitals for evaluation and treatment. Her medical history was not otherwise significant and the family history revealed that three paternal relatives had died of carcinoma.

Examination on admission was essentially negative save for a rock-hard, 7 x 5 cm mass apparently arising from the sternum just beneath the manubriogladiolar junction and extending slightly toward the left side. No adenopathy was noted. Laboratory studies were normal except for a serum alkaline phosphatase determination of 39 King–Armstrong units (normal upper limits are 13 in our laboratory). No abnormalities were detected on a metastatic bone survey and a liver scan performed with ^{198}Au was normal.

On Nov. 12, 1965, a sternectomy was performed with the insertion of a Marlex prosthesis. In addition it was deemed

Figs. 1a and b—Anteroposterior and lateral views of the chest on Nov. 9, 1965. Note the sclerosing nature and the "sunburst" appearance of this primary sternal neoplasm.

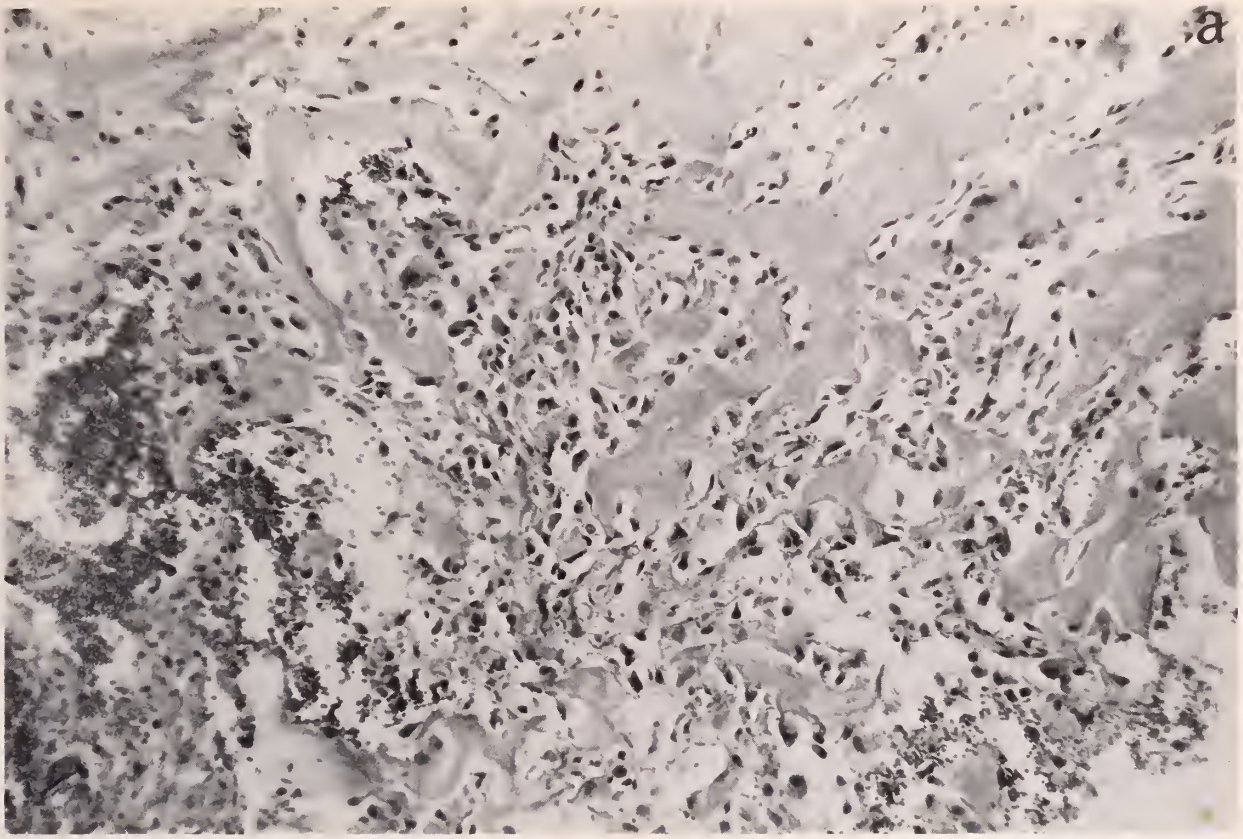

Fig. 2a—In this photomicrograph (x170) the neoplasm produces a well differentioted osteoblastic reaction with the formation of spicules and osteoid tissue. The density of the bone tissue con be ascertained by the close positioning of the trobeculoe.

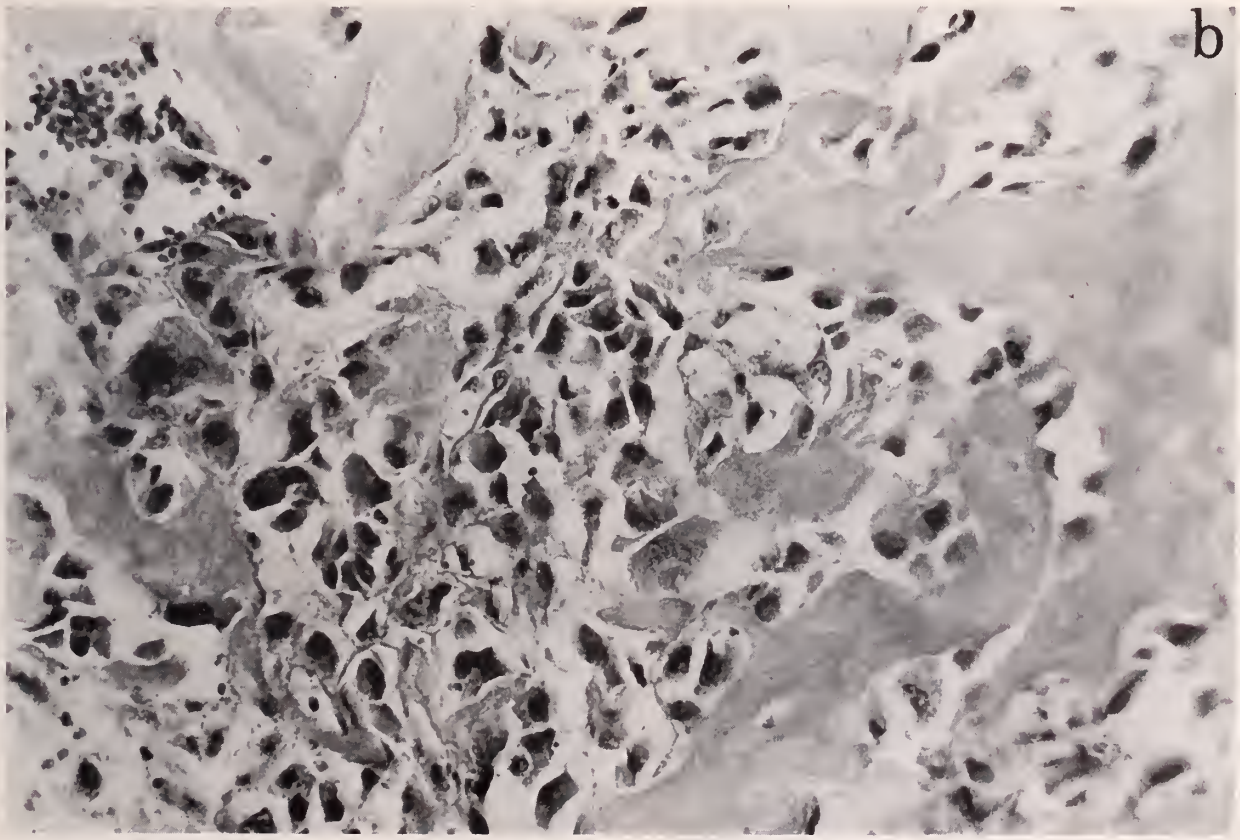

Fig. 2b—In this photomicrograph (x370) the tumor tissue makes itself most evident in the periphery of the lesion and in the capsule where there are lorge polyhedral cells with morked variation in the size of prominent nucleoli.

necessary to perform a wedge resection of part of the right middle lobe because of adhesions and possible tumor extension into this region. The patient tolerated this procedure very well and experienced an uneventful postoperative course. The pathologic report of the specimen revealed a well differentiated sclerosing osteogenic sarcoma (Figs 2a, 2b). The patient was discharged 12 days after surgery and followed uneventfully in the Surgical Outpatient Clinic until August 1966, when a chest roentgenogram revealed a recurrent mass lesion on the right above the carina and adjacent to the trachea. The patient at this time, however, felt quite well and no therapy was administered.

By November 1966 the described mass had increased in size and an enlarged right hilar mass was noted. She was admitted to the Chemotherapy Division where further evaluation including a brain scan with ^{99m}TC and a liver scan with ^{198}Au, as well as roentgenologic metastatic bone survey failed to reveal other evidence of tumor spread. She received dactinomycin (5 mcg/kg) and Cytoxan (400 mg) daily for eight days and was then discharged to home care. In December of 1966 she received another eight-day course of therapy of dactinomycin and cyclophosphamide (Cytoxan), this time as an outpatient. Marked alopecia was noted following this course of therapy.

The patient was evaluated again in January 1967 and a third series attempted, but discontinued due to persistent leukopenia. Because of persistent marrow depression she was given testosterone enanthate, 400 mg intramuscularly three times a week, for 29 doses. For the next two months she did quite well clinically and was relatively asymptomatic, except for minor signs of masculinization. A bone scan (^{87m}Sr) performed in February 1967 revealed increased uptake over the sternal region as well as D–11 (Fig 3). By this time the patient had developed bilateral lower extremity edema and moderate hirsutism was evident. A chest roentgenogram in April 1967 revealed a right pleural effusion, and following thoracentesis the patient was placed on oral

Fig. 3—Bone scan performed on Feb. 27, 1967, following the intravenous injection of 0.3 mc of ^{87m}Sr.

Figs. 4a and b—Posteroanterior and lateral views of the chest taken Aug. 23, 1967.

cyclophosphamide, 150 mg daily. She continued to lose weight but had few symptoms, except for occasional episodes of dyspnea. She returned to the Oncology Clinic in August 1967, at which time chest roentgenograms revealed ossifying metastases along the mediastinum as well as within the abdomen (Figs 4a, 4b). Clinically she still had little in the way of symptoms and the oral cyclophosphamide was continued.

Upon return to the Oncology Clinic in November 1967, progression was noted which necessitated hospitalization. She had developed edema of the face, neck, and upper extremities due to superior vena caval obstruction. During this last confinement, numerous thoracenteses were required, and the patient became progressively more dyspneic. Her course progressively deteriorated, and she died Jan. 12, 1968.

Discussion

The roentgen visualization of hematogenous hepatic or visceral ossifying metastases is an uncommon, but not unique, finding in osteogenic sarcoma.[4] Frequently, however, pulmonary metastases are the only foci of metastatic spread which can be demonstrated either roentgenologically or on postmortem examination. The response to therapy is not unusual in this case, as most of the patients reported in the literature presenting with a primary sternal focus exhibited relatively early spread and a progressive downhill course. We have, however, been rather disappointed with the response of recurrent or metastatic osteogenic sarcoma to chemotherapeutic agents employed alone. In the future, whenever possible, we would prefer to employ intravenous or intra-arterial dactinomycin, and relatively high-dose radiotherapy for the elective management of relatively nondisseminated, but locally recurrent, inoperable and inaccessible osteogenic sarcomas.

Summary

A case report of an unusual tumor in a rare locus has been presented. The response to surgery and chemotherapy has been discussed as well as our feelings concerning the palliative management of locally recurrent but nondisseminated osteogenic sarcoma.

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INTOLERANCE TO ASPIRIN: CLINICAL STUDIES AND CONSIDERATION OF ITS PATHOGENESIS

MAX SAMTER and RAY F. BEERS, JR.: *Ann Int Med* 68:975 (May) 1968

Since 1959, 182 "aspirin-sensitive" patients have been observed and studied to clarify the natural history of aspirin intolerance and permit adequate classification.

Patients sensitive to aspirin suffer from respiratory symptoms or urticaria or both. The clinical features vary from patient to patient. Childhood, adolescence, and early adulthood are not distinguished by any particular disease. Intermittent "vasomotor rhinitis" develops and is eventually followed by chronic nasal blockade and loss of intermittency. The swelling of the nasal mucous membrane becomes continuous and less responsive to vasoconstrictors. During middle age, in predominately nonatopic patients, angio-edema and rhinitis, bronchial asthma, and nasal polyposis develop. Polypectomy does not prevent the recurrence of polyps.

In the initial stage, bronchial asthma is reversible with bronchodilators and responds to maintenance doses of corticosteroids much smaller than the doses required for control of immunologically induced bronchial asthma. During this period of observation, bronchial asthma became more severe in 26 patients, some improved, and 16 became free of asthma unless attacks were precipitated by aspirin.

Many of these patients had taken aspirin previously with no reaction; no correlation exists between the frequency with which patients have taken aspirin in the past and the severity of their reaction.

In this group of patients the incidence of atopy was less than 3 percent. A significant number had a family history of atopy; 46 had children with confirmed allergic manifestations. In the occasional patient who is atopic before aspirin sensitivity develops, the clinical syndrome shifts from intermittent symptoms, with clear-cut cause-and-effect correlation, to perennial symptoms without a definite pattern.

An intolerance to acetylsalicylic acid is not an intolerance to salicylates. Salicylates other than acetylsalicylic acid given to the aspirin-sensitive patients failed to produce aspirin-like symptoms. However, indomethacin, tartrazine, and mefenamic acid, chemicals structurally unrelated to aspirin, induced severe aspirin-like reactions in aspirin-sensitive patients. These peripheral analgesics apparently act on peripheral chemoreceptors that cause vasodilation, secretion of mucus, and bronchoconstriction.

The authors conclude from this study that intolerance to aspirin is reasonably common; that evidence for an "allergic" response to aspirin is inconclusive; that the clinical triad of nasal polyposis, bronchial asthma, and life-threatening reaction to acetylsalicylic acid is a disease entity and represents a primary syndrome not previously described and recognized. □

DRINKING—DRIVING—DEATH

Figures released recently by the State Division of Health on blood tests taken from 69 motor vehicle drivers killed in the first three months of 1969, show that alcohol was involved in 46 or 67 percent. □

THERAPEUTIC DILEMMAS

COLUMBIA HOSPITAL, MILWAUKEE

These ore recorded reports, which hove been edited, of conferences held on Tuesdoy mornings, 8–9, involving porticipotion by members of the stoff of the hospitol, interns, residents, ond guests. They ore published in o selective monner monthly, except Jonuory.

Editor: HARRY BECKMAN, MD, Houghton Fellow in Clinical Research ond Consulting Physician, Columbio Hospitol

No. 19 of a Series

CHRONIC HEPATITIS

Moderator: GEORGE C. OWEN, MD

Participants: GEORGE HUGHES, MD
FREDERICK W. MADISON, MD
HERBERT W. POHLE, MD
CHARLES LOCHER, MD
GUENTHER POHLMANN, MD
GORTON RITCHIE, MD†
DANIEL H. WINSHIP, MD

Dr. George C. Owen: The deceased patient has been chosen for this morning's deliberations because she presented several of the puzzling questions that often arise in chronic hepatitis. Dr. Daniel H. Winship, Associate Professor of Medicine at Marquette School of Medicine and gastroenterologist at the Milwaukee County General Hospital, was consultant in the case and is fortunately with us to provide the principal discussion of the subject. Doctor Hughes will present the case.

Dr. George Hughes (Resident in Medicine): The patient, a 70-year-old white woman, was admitted to this hospital on April 18, 1968, with complaints of fatigue, anorexia and malaise for the past 4 months and orange-colored urine for 3 months. There had been nausea and vomiting for one week prior to admission. There was history of a myocardial infarction in September 1967, for which she had been hospitalized here, and the patient stated that she had never felt well after that episode. At that time her bilirubin was normal; the SGOT had not risen above 50 and had promptly returned to normal. She had been on warfarin (Coumadin) during that hospitalization of a few weeks and on a nitrate, isorbide (Isordil), since; and for some time both before and since, on an estrogen (Premarin) and ferrous sulfate (Feosol).

The physical examination on the present admission yielded findings that were all within normal limits in the beginning except for a suspicion of icterus. There was neither splenomegaly nor hepatomegaly; in fact the liver was small to percussion and could not be felt at the costal margin. She was afebrile and continued to be so throughout the entire course of the illness, but she deteriorated progressively, and by the third week there was obvious and increasing jaundice and severe anorexia. Examination at that time revealed vascular spiders on the face and shoulders, palmar erythema, edema of the sacral area, protuberant abdomen with shifting dullness. There was still no organomegaly. Paracentesis yielded 600 ml of straw-colored transudate with a protein content of 0.25 gm/100 ml.

The complete blood count was always within normal limits and the erythrocyte sedimentation rate never became elevated. The SGOT was elevated to 850 units on admission and continued at about that height. The prothrombin time decreased from 40% on admission, April 18, to 19% on May 6, one week before death; on this same date the serum protein was 4.2 gm/100 ml with an albumin/globulin ratio of 22.2. There was no proteinuria. Bilirubin, direct, readings between April 20 and May 6 were 4.7, 5.9 and 8.3 mg/100 ml; indirect, 3.3, 4.4 and 7.7 mg/100 ml. Alkaline phosphatase was 8 units, and thymol turbidity 11 units, on April 20 and 22. Stool was guaiac negative on April 25 and 28 and positive on April 29. Lupus erythematosus preparations were negative.

Vitamin K was administered without response. There was also no response to corticosteroids which were begun on May 3. The patient became comatose and died on May 13.

A Physician: No toxins anywhere?

Dr. Hughes: No toxins, no history of hepatitis or alcoholism.

Dr. Owen: Thank you, Doctor Hughes. Both Doctors Madison and Pohle are familiar with this case and will comment. Doctor Madison?

Dr. Frederick W. Madison: This lady was well known to me, having been a personal friend and a patient in our office for at least 16 years. She was always healthy and always observed the ordinary rules of careful living. Her husband had died unexpectedly shortly after initiation of her menopause, but she had made a good adjustment to this emotional shock. At the time of the first hospital admission the symptoms of coronary disease were atypical, but there was unequivocal electrocardiographic evidence of a posterolateral myocardial infarction. The episode was not a particularly severe one, but we were disturbed by the fact that when she came to the office for follow-up examinations thereafter she never gave evidence of full recovery—never stated that she felt well again. Each time there was complaint of weakness and "dizziness" which she felt was getting steadily worse. Finally, when Doctor Pohle saw her at home, as he will describe, and felt it advisable to admit her, neither of us had any tangible ideas of what was going on. The discovery of the jaundice on the second hospital day was a complete surprise because the possibility of hepatitis had not been in our minds. And the rapidly progressive development of liver failure left us totally frustrated and helpless. We were never able to date an acute hepatitis episode. Whether it had occurred recently or at the time of the myocardial infarction with apparently incomplete recovery, or had taken place in an unremembered earlier period, has never become known.

In any complex clinical problem one attempts to determine the pathogenesis of a disease process in

† Deceased (May 24, 1969).

terms of inciting agent, favorable environmental circumstances, and host susceptibility. In the present instance we found it extremely difficult to identify any of these factors.

Dr. Owen: Thank you, Dr. Madison. Dr. Pohle?

Dr. Herbert W. Pohle: I saw this lady professionally for the first time in September on my way home from the office after she had called to say that she had pain in her arms. I saw a 70-year-old lady in bed, who said that the pain had begun in the left antecubital fossa 24 hours before, but that it had not prevented her driving her car 89 miles to visit her daughter in a nearby city. However, on arrival there the pain spread to her left shoulder and the anterior upper chest. She spent a restless night and drove home alone on the following morning because the pain was now substernal as well as in both arms. On reaching home she vomited and decided to call us. She was pale and perspiring; blood pressure 160/90 mm Hg, pulse 60 and regular. I had her admitted to the hospital because an ischemic myocardial episode seemed the most likely explanation of the symptoms, which subsequent findings substantiated.

After recovery and return home she reached only a certain point in convalescence and was unable to go further, as Doctor Madison has explained. The next time I saw her was again on a house call after office hours. This time I saw a woman lying in bed, dizzy, afraid to turn her head or to sit up because such movements provoked vomiting. This was obviously a postural vertigo of some sort; so I ordered dimenhydrinate (Dramamine) for her from the drug store. In the artificial light I did not detect jaundice, which in fact may not have been present since we did not observe it until the second hospital day; and she said that the stool was dark, though she was careful to explain that she had been taking iron. I thought of the possibility of a central vascular disturbance or some inner ear disorder, but after 3 days of dimenhydrinate, I was called again and found her worse. I then had her admitted.

In the hospital we observed the jaundice, and with the iron omitted the stools became clay-colored. The laboratory findings, confirmatory of hepatic disease, have been presented by Doctor Hughes. The illness that brought about the final hospitalization, and her death in less than 4 weeks, was certainly a vicious one; and we were simply unable to explain what had precipitated it.

A Physician: Is it certain that the patient was not alcoholic?

Dr. Madison: I was astonished to find the consultant's note on the chart that she drank "one vodka daily." It was certainly unknown to either Doctor Pohle or myself that she drank anything at all.

A Physician: Since the drinking of vodka indicates a certain knowledge of what is available in alcoholic beverages, perhaps the possibility of alcoholism should not be entirely overlooked? I would remind the group of Dr. Edward Lennon's remark in these grand rounds recently that old ladies sometimes tipple on cooking sherry while employing it for legitimate purposes.

Dr. Madison: I certainly grant the possibility but nevertheless cannot believe that she drank habitually in a significant amount.

A Physician: Were there ever any skin eruptions, eye inflammation or myalgias during this 6 or 7 month period between the myocardial infarction and the final admission?

Dr. Madison: I would say no. She reported punctually and meticulously for follow-up examinations and I'm sure would have brought anything of that sort to our attention.

A Physician: Since iron had been prescribed at some time, had the anemia been fully studied?

Dr. Madison: No. It was minimal, and as we were concerned with healing a myocardial infarction on her first admission we did not pursue it vigorously at the time. Later, it seemed unimportant.

A Physician: Was her inanition approached through use of psychic energizers or phenothiazines or any drugs of that sort?

Dr. Madison: Her state between the two admissions was not truly one of inanition. She didn't lose weight and didn't appear to deteriorate physically. Her state seemed rather to be one that Steve (indicating Steven Moel, a senior medical student) would call a "psychophysiologic manifestation." I hesitate ever to make such a diagnosis, but possibly it is fitting here, for there were absolutely no physical findings in this interim period to support her claim of steady worsening.

Dr. Owen: Doctor Locher, are there x-ray findings?

Dr. Charles Locher (Resident in Radiology): A chest x-ray series was negative; a gallbladder x-ray series showed nonvisualization of the gallbladder, understandable in view of the liver disease; an upper gastrointestinal x-ray series provided no findings that were really contributory.

Dr. Owen: You have a scan, Doctor Pohlmann?

Dr. Guenther Pohlmann: A very interesting one in fact. The patient was injected with colloidal gold and a true miniliver showed up (Fig 1). On this type of film, a normal liver would extend about as indicated by the dotted line. Actually all we see here is a residuum of functioning liver tissue which seems to be about in the center of the right lobe. This looks more like a liver that is undergoing a subacute atrophic process rather than a cirrhotic liver. Even a small cirrhotic liver would have more irregularity in the central area than we see here. Here we have only the fairly normal liver tissue that is left when the remainder has atrophied or even been destroyed.

Dr. Owen: Thank you, Doctor Pohlmann. Doctor Ritchie will now tell us what he found at autopsy and Doctor Winship why he found it.

Dr. Gorton Ritchie: The chief interest at autopsy was of course in the liver, which weighed 670 gm.

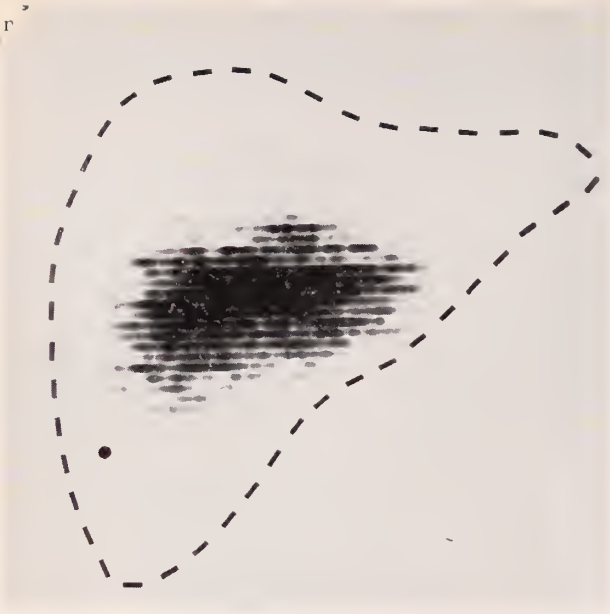

Figure 1

approximately one-half the normal weight of this organ. It was coarsely and irregularly nodular and definitely jaundiced. The nodules varied in diameter from a few millimeters to about 3.5 centimeters. On cut surface, broad bands of connective tissue were seen slicing through the parenchyma. Microscopically (Fig 2) there was found extensive evidence of a destructive process, with some of the surviving hepatic tissue comprising fragments of liver columns resembling bile ducts, although there were of course some true bile ducts remaining also; and there were areas in which liver cells and lobules were surviving in a somewhat distorted picture. In what appeared to be the destroyed part of the organ there was connective tissue with considerable congestion and a predominantly lymphocytic exudate. The picture upon the whole was that which we usually associate with regenerated liver tissue after destruction except that the presence of some neutrophils in the exudate suggested a subacute continuing inflammation. Careful search failed to discover inclusion bodies.

The heart weighed 300 gm and was flabby and brown, part of the color being due no doubt to the jaundice. I found no evidence of old or recent infarction upon routine examination of the muscle, but prior knowledge of the clinical infarction episode would have prompted more extensive search that might have been rewarding. The coronary arteries were upon the whole widely patent, being only slightly narrowed by atheromatous changes in a few places.

I think there is evidence that the cirrhotic process was of very recent advent since the spleen weighed only 60 gm; if it had been a protracted affair, I am sure that this organ would have been much larger.

Dr. Owen: Thank you, Doctor Ritchie. Doctor Winship?

Dr. Daniel H. Winship: We sometimes get ourselves into the rather smug attitude of thinking we know all about cirrhosis because we see so many patients who are really alcoholic, and a fair number with clear-cut infectious or serum hepatitis that has proceeded to chronic hepatitis and/or postnecrotic cirrhosis. However, Hans Popper, at Mt. Sinai Hospital in New York, frequently reminds us that in the vast majority of cases here in this country and throughout the world no obvious etiology is ever revealed. So we can nearly always expect to be dealing with an extremely frustrating kind of situation in most cases when the cirrhotic process has no fully obvious underlying causative factor.

When I saw this patient early in May, I thought, as Doctors Madison and Pohle did also by that time, that there were several things suggestive of chronic active hepatitis, at least sufficiently suggestive in such an ominous situation to warrant instituting treatment as for this malady. She had some spiders; there had been the quite rapid development of ascites; there were liver function tests indicating primarily hepatocellular disease; and her serum transaminase was significantly elevated. But there were

Figure 2

also things opposing this diagnosis, some of them rather important.

Almost invariably in the patients we see with chronic active hepatitis subsequent to infections or serum hepatitis the serum globulin is elevated. Hers was not. Furthermore, whether rightly or not, if the globulin, particularly the gamma globulin, is raised in such cases we equate this with the likelihood of a good clinical response to corticosteroid or immunosuppressive therapy. Since hers was not elevated, I was not surprised that she did not respond to the corticosteroids on which we placed her. What might we have expected from this therapy if she had had simple chronic active hepatitis? Well, she would have felt considerably better and would probably have resumed eating. Her serum enzymes would have come down and bilirubin decreased. Clinically she may have improved so much that persistent liver disease could have been determined only through resort to liver function tests. Biopsy, too, would show that the liver disease had not abated and had indeed perhaps worsened. But the clinical improvement might persist for as long as several years. No cures have been achieved, however, with either corticosteroids or immunosuppressive therapy.

Now in patients with a firm, fixed postnecrotic cirrhosis neither corticosteroid nor immunosuppressive therapy is in the least effective, nor indeed is any other kind of treatment. These patients may be of either sex and any age but the most usual case is that of a woman who suddenly develops evidence of liver failure and progresses rapidly to death. Apparently in this malady the inciting agent, whatever it may be or whenever it may make the initial attack, produces some liver disease which then smoulders sufficiently that the liver is able to continue functioning adequately until a point of sudden failure is reached and the patient manifests liver decompensation and soon dies. This is not the invariable but certainly the usual sort of progression in postnecrotic cirrhosis, and I think that this is what our present patient had if we must really put a name to her misfortune.

One of the striking features in her case, which has been alluded to by others and was very apparent when I first saw her in May, was that she had been sick for a long while, surely for several months. There was good evidence that she had had a myocardial infarction in September, but the nature of this continuing illness was obscure. She could not say with assurance when her clinical situation had changed: her closest estimate was, "Well, around January it seemed like I really just wasn't getting any better"—but she hadn't been getting any better since September. This is a not unusual state of affairs in chronic liver disease of almost any type and should always induce a high index of suspicion in the examiner. One might ask why bother to make an exact differential diagnosis if nothing can be done for the patient anyway? Of course the answer is that it is always a reassuring thing to have a firm diagnosis—and very occasionally a patient with chronic active hepatitis will have a spontaneous remission and in such cases it is good to know what we have been dealing with.

A Physician: Have you found this type of disease most severe in postmenopausal women?

Dr. Winship: Yes, the postnecrotic cirrhosis. But in adolescent girls and young women the chronic active hepatitis type of malady has a high incidence and a grave prognosis.

A Physician: Why was the sedimentation rate not elevated in this patient?

Dr. Winship: I do not know precisely. Had she had hyperglobulinemia we would have expected an elevated sedimentation rate, but she did not have hyperglobulinemia. Likewise, had this been a straightforward case of chronic active hepatitis we would have expected an elevated rate. However, an elevated rate is not always seen in postnecrotic cirrhosis, and I think that its absence here tends to support our tentative diagnosis of postnecrotic cirrhosis in this patient. But there was evidence in the pathological specimen of on-going inflammation and active destruction of liver cells in process, and this should have elevated the sedimentation rate. I can only repeat that I am not sure why it was not elevated.

A Physician: Would you comment on the current thinking regarding lupoid hepatitis?

Dr. Winship: This concept was introduced by Mackay's group in Australia (J. R. Mackay et al, *Lancet* 2:1323, 1957) some years ago, who found, usually in young women, a disease of the liver that was sometimes associated with lupus erythematosus (L.E.) cells in the blood or in L.E. preparations, the butterfly rash, arthralgia, leukopenia, and the like. Since that time, however, the picture has become very confused, and it is now the tendency among students of liver disease to throw everything into the category of chronic active hepatitis—which would include plasma cell hepatitis, active juvenile cirrhosis *and* lupoid hepatitis. We do not know the real meaning of the fact that patients with frank systemic lupus erythematosus may also have liver disease. Is the lupus erythematosus or the hepatitis the primary entity? I do not believe that anyone can provide the answer at present. Particularly confusing is the fact that a fairly large proportion of individuals who have simple infectious hepatitis will be found to have a positive L.E. preparation during a short period if they are checked daily, especially during their convalescence. But this is a transient finding that does not recur.

A Physician: Is there an arbitrary point in time in which hepatitis is deservedly labelled "chronic" hepatitis?

Dr. Winship: The period of 4 months is usually used, but your term "arbitrary" is altogether appropriate.

Dr. Madison: Doctor Winship, would you comment on the rationale of corticosteroid and immunosuppressive therapy in this disease?

Dr. Winship: The rationale is fairly clear but the justification for the use of the agents is somewhat less so. In the currently popular desire to explain many maladies on the basis of an underlying autoimmune mechanism, many observers have felt that this disease we are considering today is truly one that qualifies—that is to say, that if it may not have a clear-cut autoimmune causation there is at least a factor of autoimmunity which promotes its continuation. On this basis, therefore, since the corticosteroids and the anti-cancer drugs are considered to be immunosuppressive in their action, they were tried. And the clinical benefit obtained in some instances was accepted as supporting the impression that the disease is immunologically derived. Actually, however, granting that there may be an immunologic element involved, I do not think anyone can say as yet whether it is more than a merely accompanying phenomenon. A blow was actually struck at the whole concept by Good's group a few years ago (A. R. Page et al, *Am J Med* 36:200, 1964), who obtained good clinical remissions with mercaptopurine (Purinethol) and azathioprine (Imuran) in patients with chronic active hepatitis but could not demonstrate immunologic suppression in them by any of the many technics they used.

Dr. Owen (summarizing): I think it may be said that we have accomplished a considerable clarification of this subject of chronic hepatitis this morning, for which we are very grateful to Doctor Winship, and that the therapeutic dilemmas involved have been discovered to be no more than parts of the total puzzle. □

Special to the Journal

Danger Potential of Commonly Abused Drugs

By ARNOLD M. LUDWIG, M.D. and RICHARD L. PYLE, M.D., Madison, Wisconsin

THERE ARE FEW AREAS in medicine today which tend to be as controversial and clouded by misinformation and preformed biases as discussion of the dangers associated with mind-altering substances. This article is written with the hope of clarifying many of these misconceptions through a consideration of the concept of danger potential and an assessment of the current status of scientific knowledge about some commonly abused stimulant, depressant and hallucinogenic drugs.

In evaluating the danger potential of certain mind-altering substances, we have had to make a number of initial assumptions upon which to base our decisions. First, a distinction must be made between the administration of these substances by qualified physicians for scientific purposes and unauthorized, medically unsupervised use of these substances. In the latter instance, danger potential is far greater largely because of the lack of quality and dosage control for the illicit drugs and the unavailability of professional help should adverse effects occur.

Second, statements about danger need not imply a strict *causal* relationship between the administration or withdrawal of a drug and the observed result. A drug may be regarded as dangerous if there is sufficient evidence to indicate a significant relationship between the taking of a drug and the presence of some unhealthy or socially undesirable behaviors. For example, we would regard narcotic drug abuse to be closely associated with crimes against property even though this seems more related to the cost of maintaining the drug habit rather than a direct drug effect.

Third, since the introduction of any foreign substance into the body always introduces some element of risk, evaluation of danger potential must be made both on the severity of the reaction and on the incidence with which this reaction occurs, assuming such incidence can even be determined. The matter of incidence is a very important consideration. It cannot be considered logically permissible to attribute a particular danger to a drug if the incidence of that danger is not higher than that found in the general population not taking the drug.

Fourth, the assessment of danger potential must be based solely on scientific evidence and logical grounds rather than on impressionistic, anecdotal data or editorial comments. Unfortunately, in the drug abuse literature, numerous examples of *post hoc, ergo propter hoc* reasoning abound in blaming certain dangers on certain drugs. For example, because a college student has committed suicide sometime after using marihuana cannot be regarded as sufficient reason for incriminating marihuana as the *cause* of suicide. It is quite possible that the student may have used other drugs or would have committed suicide anyway.

Adapted in part from a report prepared for the Department of Justice Technical Advisory Committee on Drug Abuse, State of Wisconsin. The authors are indebted to the Committee members for their many helpful suggestions.

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DANGER POTENTIAL OF SELECTED MIND ALTERING SUBSTANCES

KEY: ++ = frequent occurrences, + = rare to occasional occurrences, +/o = controversial or conflicting evidence, o = no effect, ? = not enough information, ( ) = indirect effect

	Alcohol	Cigarette Smoking	Stimulants		Depressants		Hallucinogens	
			Amphetamines	Cocaine	Opiates	Barbiturates	Marihuana	LSD
Drug Dependence								
Psychological dependence (craving)	++	+	+	++	++	++	++	+/o
Need for increasing amounts (tolerance)	++	+	++	o	++	++	o	++
Physical dependence (withdrawal)	++	+/o	o	o	++	++	o	o
convulsions, delirium, and/or death	++	o	o	o	o	++	o	o
Psychological Disability (direct drug effects)								
Changes in perception (e.g., illusions and/or hallucinations, etc.)	+	o	++	++	+	+	++	++
Impaired judgment	++	o	++	++	+	++	++	++
Release of inhibitions with aggressive behavior	++	o	++	++	o	+	?	+/o
Mood disturbances (euphoria to depression)	++	o	++	++	++	++	++	++
Paranoid psychoses	+	o	++	++	o	+	+	++
Panic reactions	o	o	+	++	o	o	+	++
Suicide potential	++	o	?	?	o	++	?	+
Physical Damage								
Brain damage (due to acute or prolonged use)	++	o	?	?	o	?	?	?
Heart disease	+	++	?	?	o	o	?	?
Liver damage (e. g., cirrhosis, hepatitis)	++	o	(+)	(+)	(+)	?	o	o
Lung damage (e.g., cancer, emphysema)	o	++	o	o	o	o	?	o
Chromosome damage and/or birth defects	?	?	?	?	?	?	?	+/o
Death from overdose	+	o	?	+	+	++	o	o
Public Welfare								
Accidents (e.g., burns, falls, etc.)	++	+	?	?	+	++	?	?
Auto accidents and fatalities	++	o	?	?	?	++	?	?
Association with crime (e.g., stealing, assault, prostitution, etc.)	++	o	?	++	(++)	?	(?)	o
Decreased social responsibility	++	o	+/o	+	++	++	+/o	++

Fifth, the evaluation of a drug's danger potential should encompass five main considerations: (a) the acute administration of the drug, (b) the effects of prolonged or chronic usage, (c) dosage, (d) the effects due to abrupt withdrawal, and (e) the complications associated with the method or route of self-administration. Although there seems little need for clarification of the first four of these considerations, some comment is warranted on the matter of self-administration. Any drug taken intravenously, such as heroin or methedrine, may introduce the additional danger of serum hepatitis or systemic infection.

Sixth, it is essential to determine whether the taking of a mind-altering substance poses potential dangers primarily for the drug user or for the public, and whether the public danger is mainly related to crimes against property as opposed to crimes against person. Such a distinction should have important implications for legislation.

Seventh, the assessment of danger potential cannot be regarded in absolute terms. There is little question that we are a drug-taking society, and if a given illegal drug is to be evaluated for dangerous effects, some standard of comparison must be available upon which a reasonable judgment can be based. This does not mean that if illegal drugs are found to be less toxic than socially-sanctioned ones that we make available for public consumption another potentially harmful substance. Such reasoning has as much validity as advocating pneumonia for everyone because it represents a less serious illness than lung cancer. This standard of comparison, however, merely permits us to view the dangers of the illicit drug in proper perspective.

With these initial remarks, we are in a better position to judge the potential dangers of some of the more commonly abused pharmacological substances. Our appraisal of these dangers has not only been based on the assumptions given above but also on our long clinical experience with drug abusers, our research experiences with several of these substances, and an extensive review of the available scientific literature regarding the dangers of these drugs. For purposes of presentation, we have condensed most of the data pertaining to drug dangers within one chart.

In this chart we have compared two socially sanctioned, commonly abused substances, alcohol and cigarettes (containing nicotine and tar), with two examples in each of the three major categories of psychotropic drugs—stimulants, depressants, and hallucinogens. Within these three categories, the World Health Organization classified six different types of drug dependency, all of which are included in this chart. These are the morphine, cocaine, cannabis, depressant (alcohol and barbiturates), amphetamine, and hallucinogen types. However, in the classification we have adopted, cocaine and amphetamines come under the general category of stimulants, opiates and barbiturates under the category of depressants, and LSD-like drugs and marihuana under the category of hallucinogens. The opiate subcategory includes heroin, morphine, Dilaudid, Demerol, and the like; the barbiturate subcategory includes most of the barbituric acid derivatives and

their salts; the amphetamine subcategory includes methedrine, dexedrine, and the like; the marihuana subcategory includes such derivatives from the resin of the plant Cannabis sativa L. as hashish as well as synthetic preparations of tetrahydrocannabinol; and the LSD subcategory includes mescaline, psilocybin, dimethyltrptamine, and the like. In general, any of the drugs falling in one of these subcategories have similar actions.

The arrangement of the chart is also based, to some extent, on the five factors considered by the World Health Organization for defining the dangers related to drug dependency, which are (a) physical dependence [physical withdrawal effects resulting from abrupt cessation of the drug after chronic use], (b) psychological dependence or craving, (c) tolerance [the need for increasing amounts of the drug to obtain the same effect], (d) harm to the user, and (c) harm to society. The chart considers danger potential only from the viewpoint of drug dependency once developed rather than the potential for developing drug dependence. The latter may be related to many extraneous factors such as easy accessibility (e.g., alcohol) and environment (e.g., college campus, ghetto).

From the information contained in the chart, we may summarize some of the more serious complications associated with drug abuse below.

Drug Dependence

The depressants (alcohol, barbiturates, and opiates) produce the most severe drug dependence through prolonged use in terms of physical dependence, craving, and tolerance. Sudden withdrawal of alcohol or barbiturates from individuals physically dependent on these drugs may lead to serious physical consequences, such as convulsions, delirium, and often death. Although uncomfortable withdrawal symptoms are associated with the opiates, they rarely leave any serious physical disability. There are no serious withdrawal effects after prolonged usage of stimulants and hallucinogens.

As an interesting aside, LSD and marihuana, according to drug users, sometimes produce "reverse tolerance," a situation whereby the individual can "turn on" with lesser amounts of the drug.

Psychological Disability

The most severe psychological disturbances, such as paranoid psychoses and panic reactions, are more commonly found with amphetamines, cocaine, and LSD. They are not encountered with nicotine and opiate use. They may be encountered rarely with marihuana, but are more frequent when the more potent form, hashish, is used. With the exception of nicotine, all the remaining drugs impair judgment to various degrees. Aggressive outbursts and violent behavior are often found with alcohol, amphetamine, and cocaine use, but may occur rarely with the other substances. With the depressant and hallucinogen drugs, it is more common for the person to be passive and withdrawn than assaultive. Suicide potential may be regarded as quite high in those individuals who abuse alcohol and barbiturates.

Physical Damage

Of all these drugs, alcohol and cigarettes seem to be the most dangerous in terms of life-endangering, physical complications. Barbiturates and opiates are commonly associated with accidental deaths due to overdoses. The issue of chromosomal damage or birth defects due to LSD is still unresolved. Since adequate research data is lacking, it is difficult to make any definitive appraisal of serious physical damage caused by hallucinogenic substances, such as LSD or marihuana.

Public Welfare

From the standpoint of public welfare and safety, alcohol, perhaps because of its widespread use, represents the most dangerously abused drug in terms of self-inflicted injuries, auto accidents and fatalities, its relationship to crime, and physical abuse to others. Opiates and barbiturates create problems in these areas, while cigarette smoking seems completely innocuous. There is, at present, insufficient scientific evidence upon which to judge in any quantitative way whether hallucinogenic drugs have any such detrimental effects upon the public safety. However, from present knowledge, it would seem reasonable to conclude that any individual experiencing hallucinogenic effects from an adequate or high dose of a drug could be a potential danger to himself and to the public. Much more research is required to clarify this issue.

In summary, then, we find that all these drugs may be regarded as dangerous substances when used improperly or illicitly. These dangers, however, are not the same degree for all drugs and all drugs are not dangerous in the same way.

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COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacalagy and Medicine, Marquette School af Medicine, Milwaukee, and the Department of Medicine, University of Wiscansin Medical School, Madison

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Current Status of Drug Therapy in Management of Obesity

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SINCE THE SUBJECT on obesity is complex, attempts to cover all aspects would be too cursory to be of much value. On the other hand, mere presentation on the drug therapy of obesity without commenting on other approaches would be quite misleading. The purpose of this article is to emphasize the crucial points in the control of obesity and the use, abuse, and limitation of drug therapy.

Management of obesity is one of the most challenging clinical problems in our daily practice. A review of the existing publications indicates a multiphasic approach to the treatment of obesity. This is mainly because obesity is not a specific disease but a sign of underlying problems, psychological or physiological, or both. Thus, a weight-reduction program has revolved around the use of different reducing diets, appetite suppressants, exercise devices, and psychotherapy. In spite of the lack of uniform success in the control of obesity, both the physician and the patient should not be easily discouraged by the outcome.

Obesity is primarily due to overeating[1] or more precisely the result of excessive caloric intake over caloric output.[2] Perhaps, the useful criterion for diagnosing obesity should be a 20% over the standard weight for the age, sex, bony structure, and height of an individual. Such standard may aid in determining how much weight an obese person should lose and how rigid the reduction program should be.

The difficult aspect of a weight-reduction program is for the patient to adhere continuously to a prescribed diet. This requires the complete cooperation, desire, and motivation on the part of the patient. Likewise, proper and periodic follow-up of the patient and persistent personal interest from the physician will encourage the patient to continue to lose weight. Many obese individuals understand the cosmetic reason for weight reduction but are not aware of the detrimental effects of obesity. There is a real correlation between obesity and associated diseases such as hypertension, diabetes mellitus, heart disease, atherosclerosis, and thromboembolism. It is, therefore, important to educate the patients concerning the higher morbidity and mortality among the obese.

A significant point, if not the least consistent aspect in the treatment of obesity, is the criterion for successful result. Weight loss is usually significant during the first month of any reducing program. However, this short-term success generally vanishes in the subsequent months. Kurlander reported that only 8 of 95 subjects accomplished long-term reduction at the end of one year, and half of them had relapsed at the end of two years.[3] Fellows reported that of those who lost weight after one year on a reducing program, 85% of the weight loss was regained at the end of five years.[4] For this reason, a criterion for successful treatment of obesity should be uniformly established. In our opinion, a reducing program can be considered successful only when at least half of the treated patients lost 50% of the excessive body weight in one year without regaining it in the subsequent four years.

Most authorities in this field believe treatment of obesity is by the use of diet or caloric restriction. However, this approach alone frequently fails in the majority of obese patients. For this reason, supportive drug therapy is indicated when observance of diet restriction is impossible.

Drug therapy for the treatment of obesity is nonspecific. It consists of sympathomimetic amines, tranquilizers, purgatives, diuretics, and bulk-producing compounds containing cellulose.

The centrally acting anorectic or anorexigenic agents are all sympathomimetic amines. There is clinical and experimental evidence that these agents do possess appetite-suppressant properties to a greater or lesser degree and for varying periods. The currently available anorectic drugs have more or less the same qualitative effect of central nervous system stimulation. Patients taking these frequently experience insomnia, mood elevation, anxiety, nervousness, and tremor of hands. They may also note tachycardia, palpitation and vasopressive effect. Some

TABLE 1—*Available appetite suppressants*

Generic Name	Example of Propriety Name	Daily Dose (mg Range)
Amphetamine Sulfate	Benzedrine, Biphetamine	5 – 20
Benzphetamine Hydrochloride	Didrex	24 –150
Chlorphentermine Hydrochloride	Pre-sate	65
Dextroamphetamine Sulfate	Dexedrine	2.5– 15
Diethylpropion Hydrochloride	Tenuate, Tepanil	25 – 75
Methamphetamine Hydrochloride	Desoxyn, Methedrine	2.5– 15
Phendimetrazine Bitartrate	Plegine	35 – 70
Phenmetrazine Hydrochloride	Preludin	25 – 75
Phentermine resin	Ionamin	15 – 30

may have lethargy, drowsiness, and lack of ambition. Some complain of dryness of mouth and blurred vision. Others experience nausea and vomiting.

The criterion for the choice of anorectic drugs is aimed not necessarily at their efficacies but more at their relative side effects. Since only a few well controlled studies have been reported, meaningful comparison between appetite suppressants is limited. The currently available appetite suppressants are listed in Table 1.

Amphetamine (Benzedrine) was one of the earliest anorectic drugs. It is rarely used at present because of its marked cardiovascular effects.

Dextroamphetamine (Dexedrine) is the dextro form of amphetamine. It has marked central stimulating action but much weaker cardiovascular effect. It is a widely used (or abused) anorectic agent.

Methamphetamine (Desoxyn, Methedrine, etc.) differs very little, if any, from dextroamphetamine. Even the daily dose range (2.5 to 15 mg) for the two drugs is similar. There are many products in the market containing methamphetamine.

Diethylpropion (Tepanil, Tenuate) has been recommended to obese patients with heart disease.[5] Drowsiness and dryness of mouth are noted by some of the patients. At the usual therapeutic doses the intensity of central nervous system stimulation is much less than that of dextroamphetamine.

Phenmetrazine (Preludin) is one of the most widely used anorectic drugs. It has little effect on the cardiovascular system.

Chlorphentermine (Pre-sate) was introduced as a long-acting appetite suppressant but there is no clinical evidence that it is superior to the others. Clinical studies indicate that it produces less central nervous system stimulation. Patients occasionally complain of indigestion and drowsiness while taking this drug.

Phentermine resin (ionamin) releases phenylbutylamine in the gastrointestinal tract. Phenylbutylamine produces the amphetamine-like effects. Benzphetamine (Didrex) and phendimetrazine (Plegine) closely resemble phenmetrazine. There is no evidence that all of these drugs are superior to other existing anorectics.

To alleviate the intolerable side effects of central nervous system stimulation, the dose of anorectic drug frequently needs to be adjusted. To avoid reducing the dose of the anorectic drugs, barbiturates, meprobamate, or other anti-anxiety drugs can be used either in combination or as an adjunct to anorectic drug therapy. It should be pointed out, however, that tolerance to the sympathomimetic amines frequently appears on prolonged usage. Unfortunately, both the appetite-suppressant effect and the side effects diminish concurrently. Because amphetamine-like drugs have the propensity for abuse, caution should be exercised.

Other compounds which have been used as adjuncts in the management of obesity are bulk-producers such as methylcellulose and nutrient formulas like Metrecal. The use of thyroid extracts, diuretics, and digitalis in the control of obesity is nonphysiologic and should be avoided.

In conclusion, the value of anorexigenic drugs in the treatment of obesity is limited. However, in the multiphasic approach, these drugs can be used temporarily or during the early phase of a reducing program when proper caloric restriction has not been well established. These drugs, however, frequently fail when patients do not have the desire, motivation, and interest to lose weight. When special diets are prescribed, they should be palatable. Too rapid and drastic curtailment of caloric intake is not practical. Existing anorectic drugs are far from being ideal. A therapeutic trial using an anorectic along with the overall management of an obese patient is recommended. Current research is aimed at finding a compound with specific anorectic activity over a prolonged period of time in obese patients without changing the dietary habits. In the meantime, neither the patient nor the physician should be discouraged by the lack of uniform success in the management of obesity.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Health in the Ghetto

■ ONCE AGAIN THE MEDICAL PROFESSION has demonstrated what its critics can, with some rectitude, call its rigid inability to confront all of the social problems involved in the provision of health care. Again organized medicine comes away sounding like the fat white cat, content to mouth pious platitudes, and do nothing.

Recently the National Health Forum adopted a series of policy statements and resolutions making a series of demands upon the National Health Council and its member agencies. The forum was sponsored by the Council, which consists of more than 60 voluntary and governmental health agencies, professional, civic and business groups, including the American Medical Association. The forum was made up of representatives of these groups as well as 200 "consumers" of health care, 150 of whom were from "inner city" areas. The resolutions were prepared by caucuses and adopted by the forum in its concluding sessions.

Some of the resolutions reflect the current thinking among poverty activists that inclusion of the poor in the administration of Establishment agencies will somehow make those agencies more responsive to the needs of the poor. The forum, for example, asked that all health care provider agencies be reorganized to include a majority of "consumers," half of whom should be poor; that the National Health Council and its member agencies respond to the insistence of the poor that complete and personalized family care be available in one place and that the "single-disease" approach to the patient be given up; and that the forum go on record as supporting the need for a universal health insurance program to assure all Americans of their right to adequate medical care.

Certainly the failure to solve the health problems of the inner city was apparent to the non-consumer participants in the forum. Mrs. Betti S. Whaley, program director of the National Urban League, and one of the panelists, told the forum: "We must accept that our institutions do not work as well for Blacks as they do for Whites. . . . We must take a long range view of restructuring the health care system and join forces in developing consumer movements."

In commenting on this meeting, the editorial of the AMA NEWS of March 24th expressed the facile, comfortable thought that nothing could really be done about the health problems of the poor until poverty is eliminated. It quoted the remarks of Dr. Milford O. Rouse about a year ago when he made the obvious observation that ghetto dwellers have the cards stacked against them. "It doesn't do any good," said Doctor Rouse, "to bathe a child and send him out where he must play in the mud; it doesn't solve the problem to treat a particular condition in a person and send him back to live in a disease-ridden environment."

Of course not. And since that is the case, why do anything until all the other economic and social problems of the ghetto are solved first and we can be sure that when we cure a person he will stay cured? And so we will wait until the Blacks in the ghetto are more like the Whites we know, and know how to treat, and then we will treat them all alike.

Unfortunately, the problems of the ghetto are here to stay, and the people in the ghetto are not going to wait until the medical profession believes it has a sporting chance to effect cures. Black militants want no

part of gradualism, and the thinking of Doctor Rouse and others who find excuses for inactivity only infuriates them. To the ghetto poor, the fact of their poverty entitles them to special treatment to enable them to participate in the benefits of our society available to all other segments. Their humanity demands what their economic condition deprives them of.

Doctor Rouse and the AMA NEWS may speak of priorities and long range programs. But the malnourished child is here and now; the sick and infirm, the disease-ridden and the chronic sufferers have as much urgency in the midst of poverty as they do in white affluence.

The fact of hopeless poverty should provide no excuse to the medical profession. As purveyors of health care we should respond to our obligation to furnish good health care to *all* citizens, regardless of their other problems. Poor sanitation, miserable housing, malnutrition, lack of education and other problems of the inner city obviously cannot be eliminated at once—if indeed they ever can be eliminated. But attending to the health needs of the ghetto community is a good start toward including the dispossessed and the deprived in the benefits of our society. And it is a good start on a very basic level.

It is no secret to members of the medical profession that the American Medical Association, and many of the state organizations, are deeply concerned with the problem of health care in the ghetto communities, and action programs are indeed being undertaken to bring an effective measure of health care to areas where none exists at the present time. Those programs must be accelerated and publicized so that a glimmer of genuine hope can be extended to people whose frustration has already reached the point of violence.

In the present crisis—and let there be no doubt that American cities are in a crisis—the medical profession has a great opportunity to find creative solutions to the problems of health care in the ghettos without waiting for the solution of the gross economic and social problems. The opportunity is generated by our obligation to furnish good health care to all citizens of our country.

But before we can realize our opportunity, we must stop excusing medical deficiencies on the ground that society in general ought to be indicted. The health care profession must take the lead in attacking the health problems of the ghetto areas, even in the face of gargantuan obstacles and continual frustration. Health problems can't wait on other solutions.

A good place to start would be to listen to what the people of the inner cities are telling us and concede that new techniques of health care provision are required for ghetto Blacks. The medical profession must lead with compassion, and set an example of imaginative ingenuity.—D.N.G. □

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to : THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

MULTIPHASIC CHEMISTRY SCREENING

TO THE EDITOR:

It is felt that response should be made to an item in the February issue of the **Wisconsin Medical Journal,** page 68, describing an announcement by Dr. Jorris, State Health Officer, concerning the addition of multiphasic chemistry screening to the Mobile Unit of the State Division of Health. I thought that I might be in a better position to respond than many pathologists because my practice is confined to clinical consultation and acting in an advisory capacity to clinical laboratories. That is, we operate no clinical laboratory and, therefore, this activity by the Division of Health constitutes no economic hazard to my practice and personal economics cannot be construed as a primary interest.

The purposes he outlines are: (1) discover asymptomatic chronic disease, (2) establish "normal values", (3) encourage regular screening examinations and (4) enable the State Laboratory to conduct better consultative services. If any of these goals could be reached without offsetting compromise with good medical practice—the program might be worthwhile.

My first premise is that if he wishes to proceed with this tax-supported service, it should be extended to all residents of the State and not a select group. Each machine which he plans on using is capable of providing results on 438,000 patients per year. This is based on a rate of fifty patients per hour plus standards and controls with the machine operating 24-hours per day, 365 days a year. This would necessitate 10 machines such as he describes at a cost of $60,000.00 each plus an eleventh for standby. Reagent cost per year for these machines would be in excess of $875,000.00 based on a conservative estimate of $10.00 per machine, per hour. This sum is small when compared to the cost of personnel, computer time, etc. for an operation of this type. The logistics of obtaining blood sera from all residents of the State would be large but a commercial enterprise has been initiated to provide this service if desired, at a low cost to each resident. Contrary to blood pressures and chest films, chemistry profiles could be made available to all residents by merely submitting blood sera. Presently this study is being offered only to those over age 40 so that if this group were the only one to receive "benefit", the above figures could be cut to about one-fourth.

In establishment of population norms we use 95% confidence limits which means that with each procedure we will have five out of a hundred which will be outside normal limits and when we combine 12 individual procedures into a profile, 46% of the recipients will have "abnormal" results, 12%, two or more "abnormal" results and 2%, three or more "abnormal" results. If results from 1,000,000 COMPLETELY NORMAL INDIVIDUALS were sent out from the State Laboratory of Hygiene, 460,000 would have one or more abnormal results, 120,000, two or more abnormal results and 20,000, three or more abnormal results. With results sent to the recipients of this service, we would have a mass anxiety reaction and sent to the physician as unsolicited information, mass confusion.

The commercial enterprise producing this automatic chemical analyzer has produced some excellent apparatus and served as an impetus to an exciting new field, multi-

phasic screening. The machine to be used by the State Laboratory of Hygiene has problems in some of the procedures as to standardization and methodology. The determinations available are dictated by the manufacturer, not by the medical field, and are open to question as to whether they serve best for chemical screening.

We are on the verge of major breakthroughs as related to mass screening and valuable research studies are underway concerning computer analyzed historical, clinical and chemistry information on a mass basis. Noteworthy among these efforts are those being done at the University of Wisconsin—research studies! One obvious application of a chemistry profile such as they propose would be establishment of individual norms which appear to be considerably smaller than population norms. The problem at present is that biological controls and variation in the individual are in general so strict that methodology has not reached a state of proficiency to allow this application. The sum of analytical and sampling errors in the best present methodology is considerably greater than individual biological variation. This present inadequacy of methodology even extends to population norms which in most clinical chemistry determinations are too great resulting in wider than acceptable normal ranges (inclusion of abnormals). If we compound this with less than optimum methodology and attempt to apply this "information" to mass screening, we have done a disservice.

Chemistry profiles of this nature are now being performed on this instrument at many large and some small hospitals in Wisconsin. While I personally do not favor use of this particular apparatus because of limitations in methodology and standardization, this hospital application does not suffer from the lack of correlation with clinical and historical data which the Division of Health Program has.

In summary my analysis of Dr. Jorris's goals are:

(1) Some, if not several, of the procedures use less than optimal methodology necessitating wider than optimal normal limits with inclusion of increased numbers of abnormals and statistical bias in favor of one or more "abnormal results" in a large per cent of normals; all making it questionable whether the "detection ability" can offset the negatives of the program.

(2) If "normal values" were going to be established on a state-wide basis, a highly questionable procedure, only the finest methodology should be used.

(3) An old point—a blood pressure, chest film and a few chemistries will be interpreted by many recipients as a health examination; thus discouraging a history and physical examination.

(4) I can't envision how the use of this chemistry profile could enhance the consultative services of the State Laboratory of Hygiene.

(5) Perhaps most germane is the question of why a small segment of the population, even if the procedure were medically sound, should receive a partial screening at the expense of taxpayers. The program is not limited to the indigent and in addition we have apparently made health care economically feasible to all in Wisconsin through state and federal tax supported programs.

L. W. KLEPPE, MD
Beloit, Wis.

EDITOR'S NOTE: Doctor Kleppe enclosed two reprints with his letter. One, from **Diagnosis News**, March 1969, stated that,

"Multiphasic screening has its staunch and articulate advocates, but the concept is being challenged on the basis of economic cost and feasibility and on the even more fundamental grounds that, except for a limited number of disease states, detection of borderline abnormalities is not helpful to the physician and may only confuse the prognosis and treatment of the patient".

The other from **Proc. Roy. Soc. Medicine**, August 1968, reported from a symposium on Laboratory Screening Procedures and Their Clinical Implications. It concluded that,

"The Symposium questioned the value and accuracy of multichannel screening instruments, and indicated the need for greater selectivity in testing and the use of more reliable tests. Certainly, there is need for improvement in standards for multichannel instruments."

ORTHOPAEDIC AUDIO-SYNOPSIS FOUNDATION

To the EDITOR:

This letter is to enlist your help for the Orthopaedic Audio-Synopsis Foundation, and assist us in our purpose in providing a source of readily available teaching material for Orthopaedic Surgeons, Rheumatologists, and Resident Physicians. . . .

Since 1966, we have been organizing tape recorded lectures by outstanding Orthopaedic Surgeons with the intent of distributing these to teaching centers without charge, and providing for the isolated practitioners throughout the country to use on a portable tape cassette machine in his automobile or home, at a nominal charge. . . .

We believe that this project is truly a worthwhile service to increasing the dialogue of busy practicing physicians and acting to upgrade the patient care in many areas. . . .

We solicit your help . . . in . . . urging people to take advantage of the teaching and educational opportunities that can be gained through the use of a portable tape cassette recorder. . . .

Further information may be obtained by directing correspondence to the Editor, Orthopaedic Synopsis Foundation, 6317 Wilshire Boulevard, Los Angeles, Calif. 90048.

ROBERT D. SHLENS, MD

CLINICAL CENTER STUDY OF PANCREATIC TUMORS

To the EDITOR:

The cooperation of physicians is requested in the referral of patients with pancreatic tumors and watery diarrhea for a study being conducted by the Metabolic Diseases Branch of the National Institute of Arthritis and Metabolic Diseases at the Clinical Center, National Institutes of Health, in Bethesda, Maryland.

Also of interest in this study are tumor tissue, serum, or urine from such patients for assay.

Physicians interested in having their patients considered for admission to this study, or who have material for assay, may write or telephone (collect):

ROBERT S. GORDON, Jr., M. D.
Clinical Center, Room 9N-222
National Institutes of Health
Bethesda, Maryland 20014
Telephone: 496–4181
(Area code 301) □

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It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MINUTES OF COUNCIL MEETING

MADISON, FEBRUARY 22–23, 1969

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 2:00 p.m. on Saturday, Feb. 22, 1969, at the State Medical Society.

Voting members present: Doctors Bayley, Nordby, Stoops, Carey, McRoberts, Rohde, Boren, Ludwig, Manz, Van Hecke, Egan, Chojnacki, Hollenbeck, Wright, President James, and Speaker Behnke; present Saturday only, Doctors Dettmann, Houghton, Sullivan, and Past President Kief.

Others present: President-elect Callan; Vice-speaker Nereim (Saturday); AMA delegates Bell and Galasinski; alternate delegate Collentine (Saturday); AMA trustee Simenstad; Messrs. Murphy, Kluwin, Gill, and Tiffany (Saturday), consultants; Messrs. Crownhart, Koenig, Thayer, Doran, Reynolds, Maroney, Brower, LaBissoniere, Johnson, Miller (Sunday); Mrs. Anderson, Misses Cordts and Pyre.

Special orders: Messrs. Wilbur Schmidt and Frank Newgent, State Department of Health and Social Services, Saturday; Doctors Teresi, Carlson, Richards, Section on Pathology; Doctors Wixson, Doolittle, Feulner, Scott, Rice, Stiles, Mendenhall, Vogel, Derus, Manier, Gladstone, and Foerster representing their respective specialty sections Sunday morning.

2. Report of Council Committee on Scientific Medicine

Doctor Van Hecke reported that the committee met in review of the 1969 Annual Meeting program, and considered several recommendations of the Commission on Scientific Medicine as to future programs. He presented the following recommendations for Council action:

A. Nonscientific Program Subjects

On motion of Doctors Van Hecke–Stoops, carried, the Council approved the recommendation that henceforth requests for inclusion in an Annual Meeting program of subjects of a socio-economic rather than an inherently scientific nature be referred first to this Council committee.

B. Technical Exhibits

The Commission on Scientific Medicine had proposed that consideration be given to discontinuing rental of space to commercial, or technical, exhibitors because of current reluctance on the part of drug firms and others to participate, and that expenses be borne by membership dues or assessments.

On motion of Doctors Van Hecke–Stoops, carried, the Council approved the committee's recommendation that the format of seeking financial support through exhibitors be retained through 1974.

C. Options on Future Annual Meeting Space

On motion of Doctors Van Hecke–Chojnacki, carried, the Council approved the committee's recommendation that options be exercised on headquarters space at the Sheraton–Schroeder and Milwaukee Auditorium for 1972 through 1974, and that headquarters be moved to the Pfister Hotel for the 1971 meeting.

D. Regional Scientific Program Proposal

The committee considered the suggestion that Wisconsin join with several states in presenting one regional scientific program per year, and suggested that this proposal be referred to the Executive Committee because of ramifications beyond scientific programming. The chair so ordered.

E. Future Committee Meetings

The committee plans to meet regularly before each Council meeting to review scientific matters.

F. Special 1969 Program

The committee was advised of an invitation extended through the Commission to Senator Nelson to speak during the Thursday afternoon program, and in view of objections to that scheduling from the scientific sections whose programs would be interrupted, the committee proposed that with consent of the Speaker, he be asked to speak following adjournment of the House of Delegates on Wednesday morning. On motion of Doctors Van Hecke–Behnke, carried, this was accepted under the circumstances.

3. Title XIX—Medicaid

Before calling on Mr. Schmidt, Chairman Nordby read a policy statement proposed to the Council by the Executive Committee, emphasizing care in the matter of utilization of institutional facilities, in that nursing home and hospital care account for the greatest part of the cost of this program.

Messrs. Schmidt and Newgent presented recommendations they contemplated making to the Board of Health and Social Services in light of the deficit caused by underestimation of Medicaid expenditures for the biennium ending July 1, 1969. These involved legislative amendments and new administrative policies.

There was lengthly discussion and exchange of views on the overall operation of Medicaid in Wisconsin and the role of physicians. In response to a question, Mr. Newgent said that for the recorded period of June 1967 to August 1968, the average amount paid for physicians' services remained the same. He acknowledged that the public is nevertheless convinced that excess costs are the "fault" of doctors.

The Council delayed action on the proposed policy statement until after dinner recess, pending opportunity to edit and duplicate it for individual review.

On motion of Doctors Kief–Hollenbeck, carried, the statement was then adopted as follows:

"The Council of the State Medical Society of Wisconsin, comprised of representatives of the profession from every area of Wisconsin, has reviewed the general performance of its members during the past two and one-half years under major tax-supported health programs, including Title XIX benefits under the Medical Assistance Payments Act in this state.

"As physicians, the Council members are well aware of the many administrative and other non-medical difficulties which the profession encounters in caring for patients who

fall within the various categories covered by such programs. It has not forgotten that patient needs must always remain the profession's primary concern.

"The Council commends the practicing physicians of this state for keeping charges for professional services to patients under the Medical Assistance Payments Act within reasonable limits. It is confident that the profession will continue its noteworthy performance in the area of economic medicine.

"The Council asks that the profession continue to make careful determination of what type of institutional care is needed, and the limits of its medically warranted duration, where home care is not a feasible alternative for the patient. To that end it urges the importance of having each physician establish, and continually review, treatment and other professional decisions to assure that they are realistic, and that they will result in the best use of public monies consistent with sound patient care.

"The physician, in the course of treating those who are beneficiaries of government health programs, must himself distinguish and must emphasize to patients, families and administrators, the marked difference between rehabilitation programs and custodial care, and the reasons both or only one may be indicated in a particular situation.

"The continued performance outlined in this statement will best assure the discharge of the physician's dual role of an always concerned professional and a responsible citizen.

"It is recommended that within the limits of the time of the officers and Society staff, the substance of this report and its underlying considerations be discussed with officers and members of county medical societies which might be encouraged to meet on a councilor district basis."

4. Approval of Minutes

On motion of Doctors Egan–Van Hecke, carried, minutes of the October 1968 Council meeting were approved as published.

5. Report of Planning Committee

The committee reported it had met in December with a representative of the Wisconsin Society of Anesthesiologists to discuss the latter's objections to the present administration of claims submitted by physicians on behalf of nurse anesthetists. It was pointed out that under present wording of the WPS contract, the Commission on Medical Care Plans feels that it must pay for services billed and signed for by a physician.

After discussing alternatives for dealing with payment for ancillary health services, the Planning Committee recommended to the Council that it request the Commission on Medical Care Plans to consider separate billing for nurse anesthetists and other ancillary services.

It was agreed that physician authorization of such services with the name of the individual and type of ancillary service being rendered should be noted on the claim form. The committee felt that this type of separate billing, using the present claim form with the addition of items for billing of ancillary health services, would enable WPS to pay for such services on the basis of the value of the service performed rather than having to pay for such services as if they were actually performed by the physician submitting and signing the claim form.

It was noted also that WPS liability for payment of services is governed by the contract in force at a given time and that this liability will need to be extended at some point if nurse anesthetists and other designated ancillary services are to be covered.

This was accepted by the Council for information pending consideration by the Commission on Medical Care Plans.

6. Report of Committee on Economic Medicine

Doctor Sullivan reported committee recommendations on the following subjects in the absence of Chairman Schulz:

A. Professional Liability Claims

The committee recommended a mechanism of adjudicating professional liability claims prior to suit with a view to avoiding compromise settlements on cases felt to be groundless, and holding down the cost of malpractice insurance. In discussion, it was suggested that a panel system would be preferable, such as that in New Jersey.

On motion of Doctors Sullivan–Bayley, carried, the Council requested the committee to continue study of the problem.

B. Catastrophic Liability Coverage

The committee reported as a matter of information on the availability of catastrophic professional and personal liability coverage.

C. Comprehensive Health Expenditures Commission

The committee considered the recommendation of Doctor Kief as President on the creation of such a commission, and proposed that the facilities of the University of Wisconsin at Madison be explored as a means of developing and analyzing health care expenditures, and that other recognized Wisconsin health agencies be included as cosponsors of this activity.

On motion of Doctor Sullivan, seconded and carried, the Council authorized such explorations but made no commitment on fiscal involvement. Doctor Bell suggested that progress on the AMA study being conducted by reason of a Wisconsin resolution last December also be checked.

D. Title XIX Administration of Small Claims

The committee considered the problem of costs to physicians' offices in frequent billings to Title XIX for relatively small amounts.

Mr. Doran explained to the Council that an agreement had been reached with the Department of Health and Social Services that monthly billing is not necessary in all circumstances.

E. State Life Fund

The Council accepted the suggestion of the committee that in some appropriate fashion a news item be published to members on the State Life Fund.

7. Report of Finance Committee

Doctor Bayley made the following report for Council information and action:

A. Employee Retirement Plan

The Council had earlier authorized the Finance Committee to take final action on a revision of the present plan to a funded plan with a pure retirement concept as distinguished from a savings account type of plan.

The committee authorized consultants to submit the proposed plan to the Internal Revenue Service for advance approval in substantially the form presented to it, and will take final action after that step.

B. WPS Investments

At the request of the Commission on Medical Care Plans, in light of some questions over the loss taken on investment transactions in 1968, the committee heard a presentation from investment counsel retained by the Council in 1961. Representatives of Scudder, Stevens and Clark explained their reasons for recommending con-

version of short term paper to long term bonds and sustaining a paper loss in the process, some of which was recovered before the end of the year.

C. Quarterly Reports and Committee Meetings

Doctor Bayley reported that the committee has requested quarterly reports on general fund expenditures and plans to meet in quarterly review of them in relation to the budget and to see where any tightening is necessary.

D. 1969 Operating Budget—SMS General Fund

Doctor Bayley discussed areas of the budget in which the Finance Committee had made reductions in its two sessions to bring estimated expenditures to the minimum. The Council was asked specifically to approve discontinuing publication of complete proceedings of the House of Delegates, including all reports and resolutions introduced, which have been carried in a supplement to the Journal at a cost of about $4,500. Instead, only the summary of actions prepared for members of the House would be printed in the Green Sheet of the Journal.

On motion of Doctors Chojnacki–Wright, carried, the Council approved this recommendation.

The total estimated expenditures for 1969 ($590,400) against anticipated income ($557,500) left a deficit of $32,900. Experience in 1968 resulted in a $36,000 deficit so that reserves will be reduced to about $40,000 by the end of 1969. Doctor Bayley reported that the committee presented the budget without recommendation on offsetting the deficit.

On motion of Doctors Egan–Ludwig, carried, the budget was adopted as presented.

Doctors Sullvan–Van Hecke moved that there be no increase in dues. This motion lost.

On motion of Doctors Bayley–Ludwig, carried, the Council recommended a $25 dues increase in 1970 and that a quarterly payment method be investigated.

The Council recessed at 5:50 and reconvened at 7:30 p.m. with an executive session on executive salaries requiring Council action.

8. Report of Executive Committee

Doctor James made the following report of Executive Committee recommendations other than that relating to Medicaid on which action is reported above:

A. VA Staff Physicians

The Monroe County Medical Society requested State Society approval to use of the services of VA staff physicians as consultants to the medical staff of Tomah Memorial Hospital.

On motion of Doctors Ludwig–Bayley, carried, the Council approved the recommendation that such approval be granted providing the physicians are licensed to practice medicine in Wisconsin.

B. "Green Paper"

On motion of Doctors Chojnacki–Wright, carried, the Council approved publication in the Journal, with reprints to legislators and others, of a digest of official positions adopted by the Society on key legislative and socioeconomic issues.

C. Wisconsin State Medical Assistants Society

On motion of Doctors Stoops–Kief, carried, the Council referred to the Speaker the request of the WSMAS to address the House of Delegates with the recommendation it be accommodated if possible.

D. Hospital Staff Privileges

The Executive Committee noted the resolution adopted by the AMA House of Delegates last December calling upon its members to oppose attempts of hospital boards and administrators to assume the role of delineating staff privileges, and also was informed of revisions of the standards of the JCAH currently under consideration which include a requirement that the advice of medical staffs be utilized in determining privileges.

On motion of Doctors Van Hecke–Hollenbeck, carried, the Council reiterated its availability to arbitrate disputes stemming from questions on the delineation of such privileges.

E. Scientific Sections

The Executive Committee discussed a request for creation of a Section on Neurology and recommended that it not be implemented at this time. It is understood that the neurologists can continue to have separate scientific programs, but there is not sufficient reason to divide the existing Section on Psychiatry and Neurology. On motion made, seconded and carried, this recommendation was approved.

9. Commission on State Departments Election

On motion of Doctors Chojnacki–Stoops, carried, George Nadeau, M.D., was elected chairman of the Division on Vision.

10. CES Foundation Trustees

It was reported for information that the following had accepted election as nonmedical members of the board of trustees: Mr. George Becker, Fond du Lac; Mr. Donald S. DeWitt, Oconto; Judge Carl Flom, Madison; and Mr. L. O. Graf, Milwaukee.

11. "Emergency Care and Transportation of the Injured"

On motion of Doctors Stoops–Bayley, carried, the Council gave its endorsement, without fiscal implications, to this program to be conducted in August at the Wisconsin Center by the American Academy of Orthopaedic Surgeons and the American College of Surgeons.

12. Report of Commission on Medical Care Plans

Mr. Koenig summarized subjects recently considered by the Commission which will be contained in its annual report to the Council and House of Delegates in more detail:

A. Continuing administration of Medicare on the basis of usual, customary and reasonable fees with advice of local committees pending possible new directives from HEW.

B. Offering of a new combination of benefits incorporating deductibles or coinsurance, to bring patients into an awareness of health care costs and thereby reducing demands for nonessential hospitalization, for example, coupled with the charge card to permit budgeting the costs of uncovered services.

C. Phasing out remaining contracts held by those over 65 which carry liability for some benefits paid under Medicare, and encouraging substitution of Medicare-Plus coverage.

D. The decision not to enter at this time into an agreement with the Wisconsin Dental Service Corporation to sell its dental contract and subcontract administration of the dental portion of Medicaid.

E. The Commission requested the Council to send representatives to meet with a particular area specialty group to discuss the implications of a proposed gen-

eral increase in the level of fees. Doctor Nordby informed the Council that he had taken the liberty of naming Drs. P. B. Mason, D. N. Goldstein, and J. W. McRoberts to meet with this local group.

F. Authorization of a rider with appropriate premium to provide benefits for eye examinations and eyeglasses at the request of the Section on Ophthalmology.

13. Committee on Medicine and Religion

Mr. Thayer reported on the organizational meeting of this new committee which will have an exhibit at the Annual Meeting to present its program for the state.

14. Legislation

A. Family Planning

The Council was provided with an analysis of two bills before the Legislature on this subject, 30S and 56S, and was also advised of another bill introduced at the request of a physician, 226S, which makes family planning a felony. Separate motions, seconded, to support 56S and 30S lost, and on motion of Doctors Bayley–Van Hecke, carried, the Council reaffirmed the position of the House of Delegates as taken in 1967 and reaffirmed by it in 1968, to support in principle legislation which would remove birth control information and devices from a statutory definition of indecent articles, and concur with the position of the AMA in its statement that physicians must assume the role of leadership in the area of family planning in our society.

B. Licensure of Psychologists

Doctors Egan–Chojnacki moved that the Society carry on efforts to oppose the licensure of psychologists unless they are willing to be under the supervision of a physician or take the basic science examination. The motion carried and the chairman interpreted it as reaffirmation of the present position of the Council adopted in October, 1968.

Doctor Egan suggested that the Division on Nervous and Mental Diseases be asked for its present position on the subject.

15. Delegate Caucuses

On motion of Doctors Van Hecke–Wright, carried, the Council requested that staff arrange caucuses as in the past, upon request of the districts, and that component societies be so informed.

16. Further Report of Executive Committee

Minutes of the November and January committee meetings were filed with the Council for information. They reported many items of routine nature or subjects otherwise on the agenda. The Council took action on two matters:

A. Special Committee on Shortage of Physicians

On motion of Doctors Stoops–Ludwig, carried, the Council approved constitution of a special committee by the chairman to follow through on suggestions made at the special conference on the shortage of physicians held by the Society in December.

B. Certification of Ancillary Health Personnel

On motion of Doctors Ludwig–Wright, carried, the Council approved the following statement proposed by the ad hoc committee on the Medical Practice Act:

"Voluntary certification by the national organization of members of the various ancillary health fields is preferable to any form of registration or certification by the state; but if certification or registration is proposed, a commission to evaluate the necessity for registering or certifying a particular ancillary health field should be established. In addition, it is recommended that a mechanism for central registration or certification be established and that such system make use of the appropriate accredited colleges and universities of the state to establish the standards used as the basis for registration or certification."

The Council recessed at 9:35 p.m. on Saturday and reconvened at 10:00 a.m. on Sunday after meeting as members of the SMS Realty Corporation.

17. Licensing of Medical Laboratories and Blood Banks

Doctors Teresi, Carlson and Richards presented legislation proposed by the Section on Pathology to license medical laboratories and blood banks. This was discussed at length and exceptions were taken with reference to the number of doctors of medicine on the advisory board; inclusion of an osteopath on the board; and limitation of the exemption to two physician offices rather than to four or five.

Doctors Van Hecke–Chojnacki moved that the Society endorse the bill as presented by the Section on Pathology with such suitable modifications as the Society feels are necessary on the above points. An amendment by Doctors Manz–McRoberts to exempt all laboratories operated by physicians in connection with diagnosis and treatment of their own patients lost, and the original motion carried.

18. Meeting with Section Representatives

Chairmen of all scientific sections had been invited to meet with the Council or send a representative for a general discussion of their programs and problems, and the desire of the Council to present a united front on various issues facing medicine. Several sections indicated concern with specific legislative proposals, and the Section on Surgery inquired as to the status of its proposed section membership qualifications which require Council approval. (This was in effect tabled by the Council some months ago when a special committee on section organization was requested to review the entire subject.)

19. Adjournment

The meeting adjourned at 12:10 p.m.

C. H. Crownhart
Secretary

Approved:

E. J. Nordby, M.D.
Chairman

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SECTION OPHTHALMOLOGY

JUNE 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

SECTION MEETING IN MILWAUKEE

The Section of Ophthalmology of the State Medical Society held its annual meeting in Milwaukee, May 15. 1969. The following men were elected to lead the section for the coming year: Drs. Ralph Teitgen, Milwaukee, chairman; John Conway, Menasha, vice-chairman; and Carl Schmidt, LaCrosse, secretary. The Section will be represented at the House of Delegates of the State Medical Society by Dr. Carson Parks, Milwaukee, delegate; and Dr. George Anderson, Stevens Point, alternate.

At the business meeting H. B. Maroney of the State Medical Society reported that over 100,000 bookmarks had been distributed to Wisconsin school children. The bookmarks explain the difference between an ophthalmologist, optometrist, and optician. The printing was financed mostly by the voluntary dues contributions of ophthalmologists with distribution being done by the Women's Auxiliary of the Opticians of Wisconsin.

After the business meeting Dr. Alston Callahan, Birmingham, Ala., spoke about "Recent Advances in Plastic Surgery." Dr. Harry Easom, Milwaukee, then conducted a clinicopathological conference for Marquette School of Medicine in which cases were discussed by Drs. James Allen and Harry Roth of Madison, representing the University of Wisconsin.

SAFETY GLASSES

Dr. Ephraim Friedman, professor and chairman of the Department of Ophthalmology at Boston University, spoke at the National Society for the Prevention of Blindness Annual Meeting in Milwaukee May 16. He told about his efforts to get the Massachusetts legislature to pass a bill requiring all lenses to be made of plastic safety glass. The bill also included a requirement that all spectacle frames be made of noninflammable substances.

He reported that during the last year Alaska was the first state to enact such legislation. Similar legislation has now been introduced into several other state legislatures. He thought it was very likely that similar legislation would be introduced into the Wisconsin legislature within the next several years.

UW OPHTHALMOLOGISTS SPEAK IN FRANCE

Dr. Guillermo de Venecia and Dr. Matthew D. Davis from the Division of Ophthalmology, University of Wisconsin, attended the International Symposium on Fluorescein Angiography June 9 to 14 in Albi, France.

Doctor de Venecia presented a paper on "Histology and Fluorescein Angiography of Retinal Microaneurysms in Diabetes Mellitus."

Doctor Davis presented a scientific exhibit on "The Natural Course of Diabetic Retinopathy" and participated in the panel discussion.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

Dr. Alston Callahan, Birmingham, Ala., spoke at the University Club to the Milwaukee Ophthalmological Society on May 15. His subject was "Recent Advances in Plastic Surgery," with especial emphasis on upper and lower lid reconstruction, tumors of the lids, socket reconstruction, and fractures of the orbit.

NEW OPHTHALMOLOGIST FOR CUDAHY

Dr. Gerald W. Wadina, who is finishing his ophthalmology residency at Marquette, will be opening an office at Cudahy in July.

Doctor Wadina is a 1965 graduate of Marquette School of Medicine. He did his internship at the University of California Los Angeles affiliated hospitals.

WISCONSIN–UPPER MICHIGAN SOCIETY OF O. & O.

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology will meet at Dell View Hotel, Lake Delton, Sept. 26, 27, and 28.

A more central location was picked this year to enable more members from the south and west to attend. Mornings will be reserved for golf and recreation, except for a brief business meeting Sunday morning. There will be a dinner on Saturday evening.

Dr. Joseph Haas, Chicago, will speak on eye surgery and Mr. Jack Copland, Milwaukee, will speak on optical problems. Dr. Henry Williams, Minneapolis, Minn., will speak on ear, nose, and throat problems. There will also be panels and short presentations by members of the society. New movies on surgical procedures will be shown if time permits.

Those physicians interested in more information or in joining this society should contact George L. McCormick, MD, Secretary, 102 East Main Street, Waukesha, Wis. 53186.

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SHIGELLOSIS CONTROL IN INSTITUTIONS

By ELLISON F. WHITE, M.D., PAUL J. LAWRENCE, M.D. and VITOLDAS BALCIUNAS, M.D., Union Grove, Wisconsin

THIS REPORT deals with the control of institutional shigellosis. To our knowledge it is the first reported attempt to eradicate endemic shigellosis by using two drugs concurrently. Evaluation and method of treatment were used at one of the three colonies for mentally retarded in the State of Wisconsin.

Southern Colony had been plagued with recurrent epidemics of shigellosis for over 10 years with an annual average of 140 culturally proven cases varying from 32 cases in 1956 to a peak of 290 cases in 1959. Until 1965 one drawback to complete control was lack of isolation facilities. A new hospital was opened in 1965 with a 26-bed isolation section.

Up to this time control of outbreaks had been attempted by isolation of entire wards and the administration of various drugs, such as succinylsulfathiazole (Sulfasuxidine) to all ward residents. Since there was a continual shift of patients from ward to ward during the course of the year, we were apparently transferring chronic carriers who had no clinical symptoms. The *Shigella* organisms were both *flexneri* and *sonnei* strains. All patients with the diarrhea had stool examinations for enteric bacteriology and were treated before positive findings were reported. Patients were not taken out of isolation until three negative cultures were obtained.

Since we were unaware of the source of these outbreaks and believing that the organism was endemic in this institution, it was evident that we needed some help before starting a campaign of eradication.

The Medical Director requested through the communicable disease section of the State Division of Health, that the US Public Health Department help evaluate the status of chronic shigellosis at the Colony, and on Sept. 13, 1965, two officers of the Epidemic Intelligence Service (EIS) arrived from Atlanta, Ga.

It is not the purpose of this report to explain their methods; however, this information may be obtained from the office of the Communicable Disease Center, USPHS, Atlanta, Ga.

Their efforts soon resulted in findings that 78% of the cases occurred in patients who lived in or were transferred from 2 of the 15 cottages. It then became a problem of finding the chronic carriers in these two buildings. Before the arrival of the EIS officers, our staff had developed an eight-day treatment with what we felt was the best drug to eliminate the bacteria entirely so that the patient was free of chronic ability to reestablish an outbreak. Chloramphenicol (Chloromycetin) was given starting on the day the patient was proven by culture to have shigellosis. Suspicious cases were referred to the hospital isolation section. Three-day stools were examined and after the last stool culture was taken, specific treatment was started if any one of three cultures was positive. Chloramphenicol was given orally in a dosage of 250 mg four times a day for eight days. Three days after the end of treatment, three more cultures were taken. If these were all negative, the patient was considered cured and returned to the ward.

The eight-day treatment regimen was originally selected quite arbitrarily and appeared to be quite effective. However, in an effort to avoid toxic effects, the duration of treatment was later reduced to seven days. Positive cultures were found frequently after seven days of treatment and the duration was again increased to eight days. We felt that there might be some strains of *Shigella* that had become resistant to chloramphenicol, because this drug had been used

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previously on many patients to control severe infections which did not respond to other antibiotics.

Both the Medical Director and the Assistant Medical Director had formerly worked in the field of tuberculosis and recalled that much work had been done on the combined use of two drugs with much more effect than single-drug therapy. Walsh McDermott[1] in the Amberson lecture of May 1962 discussed the use of two drugs in the control of several organisms, and we felt it might eliminate resistant organisms by using neomycin along with chloramphenicol.

The conventional explanation of efficacy of two-drug therapy is that one drug kills those microbes that are genetically resistant to the other drug. This, of course, is true only if each drug is fairly effective when used alone. We feel that McDermott's concept —that the therapy works principally by acting on the same microbe—does not invalidate the first concept, since the results are the same.

Following our decision all patients, including the supposed carriers, were then treated with an eight-day course of neomycin, 500 mg four times daily, along with the chloramphenicol dosage of 250 mg four times daily.

A period of controlled follow-up was established, using as key personnel the head nurse in the isolation section of the hospital, the nurse in charge of a cottage, and the chief medical technologist. Each presumed successfully treated case was cultured by rectal swab once a month for one year. All cultures of all treated patients proved negative. To insure that no new case came into the Colony, all newly admitted patients were cultured in the admission section of the hospital and not released to the ward until three cultures were negative.

Previously, a culture routine had been required for all new patients plus the culturing of all new employees when they made application, but only one culture was required for employees and new patients. No cases of positive findings among either previously treated or new patients have been found to date. Since our supposed sterilization of the patients, one employee has had shigellosis and she was treated by her personal physician before coming to work. The Public Health officers from Atlanta suggested to our Medical Director the possibilities of setting up control vaccine programs for shigellosis; however, since there were no cases for 17 months, no program was started. At the end of 17 months a patient with diarrhea on one of the wards was found to have culture positive for shigellosis. He was immediately isolated and the entire ward was closed off. Subsequently, three more cases were found in this group which consisted mostly of bed patients.

The boy who was first proven to be infected was of recent admission and the possibility of his bringing the disease into the Colony was considered. He had one negative culture on admission.

We had enough confidence in our treatment to feel that we had eliminated the disease in our Colony.

On discussion it was brought out that on proved cases we took three cultures, one a day for three days, and that many times only the second or third culture was positive. Thus, infected patients could have been admitted since we were taking only one culture on new admissions. New standards were set up and at this time five months after our four-case epidemic, there have been no new cases. All new admissions and all employees must have three negative stool cultures before they are allowed to mix with other patients in cottages.

Discussion

Since we have had good results with the use of chloramphenicol (Chloromycetin), we have continued to use this drug in the treatment of shigellosis. However, some medical men are adverse to the use of this drug because of its reported toxicity. There are other drugs that can be substituted for chloramphenicol. A recent report by Haltalin *et al*[2] claimed that in their series ampicillin was superior to sulfadiazine, having only 6% failures as compared to 39% with the use of sulfadiazine. In our series our intention was to use two drugs either of which when used alone would eradicate the infection. However, if there was a slight possibility of the bacillus having some inherent resistance, this particular possibility was decreased by use of a second drug along with the first drug.

Other combinations which we feel would be effective are: neomycin-ampicillin, neomycin-oxytetracycline (Terramycin), or streptomycin with any of the three drugs mentioned.

We believe that the sulfonamides at this time are too inadequate to be used alone or in combination.

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CONTRACTION OF THE GASTRIC ANTRUM FOLLOWING A LONG-TERM GASTROENTEROSTOMY

THOMAS L. CARTER, MD and WILLIAM MARTEL, MD, Madison General Hospital, Madison, Wis.: **Radiology** 91:514–516 (Sept) 1968

It is not generally appreciated that the gastric antrum may become atrophic and contracted long after simple gastroenterostomy. The radiologic appearance of the antrum in these cases may be confused with that of an infiltrating carcinoma. A needless laparotomy may be avoided by an awareness of this diagnostic possibility. Two cases are illustrated. Differentiation from neoplasm is usually possible. The mucosal margins are smooth and distinct without evidence of mural thickening. The stomach is pliable and the patients present no clinical signs of advanced carcinoma. □

METASTATIC TUMORS TO THE CENTRAL NERVOUS SYSTEM

By PAUL C. BUCY, M.D.

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THE ATTITUDE that metastatic carcinoma is a hopeless incurable condition for which nothing can be done is often wrong. This defeatist, negativistic approach denies to many patients relief from disabling and disagreeable symptoms. This is inexcusable. Our responsibility as physicians is to relieve distressing symptoms and to prolong life as long as it is possible to do so in a manner that all of us would accept. The fact that the condition will ultimately prove fatal is no excuse for doing otherwise. Ultimate fatality faces all of us; with or without a malignant tumor this may be tomorrow or years hence. Patients suffering from malignancy should not be denied any reasonable help because their impending death seems more apparent. Our problem then is to determine as accurately as possible what we can do and whom we can help.

The correctness of this approach has been clearly demonstrated recently by our review of the results of treatment of glioblastoma of the brain—the most malignant of all primary tumors of the brain.

In years gone by, it was commonly accepted that glioblastomas were malignant, were hopeless, and that when the diagnosis had been established either by biopsy, angiography, or other means, nothing could be done. When this course is followed, all patients are dead within less than a year. However, if a different attitude is adopted, the results are quite different. If the tumors are surgically extirpated as thoroughly as possible, if dexamethasone is used pre- and postoperatively and as indicated in the course of their treatment, and if radiation therapy is fully utilized, over 27% of the patients will be alive one year after operation and some will live seven, eight, or nine years in good condition. Furthermore, regardless of how long they live, the vast majority of patients will enjoy a happier, more self-reliant condition than if nothing is done.

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With only a biopsy and decompression *no* patient in our study was in excellent or good condition three months after operation. On the other hand, whereas over 63% of the patients properly treated were in poor condition prior to operation, 62% were in good (18.4%) or excellent (43.4%) condition three months after operation and almost 20% at one year. Not only have these patients lived longer and in better condition than with inadequate treatment, but there is reason to hope that with renewed effort some patients with glioblastoma may ultimately be cured.

Our study of glioblastomas has also revealed another important and somewhat unexpected fact. Although the results in patients in poor condition and patients with tumors in the left cerebral hemisphere with disturbances of speech and right-sided weakness have been somewhat poorer, the results have not been strikingly inferior to those with patients in better condition or with tumors in other locations. In other words, even those patients who have commonly been regarded as hopeless can often be restored to a relatively healthy condition for a considerable period of time.

The situation in patients with metastatic tumors of the brain is similar. They, too, can be helped—their lives prolonged and their symptoms relieved in many instances. Statistics here are of little value. We are dealing with individuals and individual problems. It is obvious that not all patients with metastatic malignancy can be helped or should be subjected to surgical treatment. The surgeon's initial problem is to determine which ones he can probably help. For this purpose we have developed certain rules to guide us. A poor general physical condition is a contraindication to operation. Evidence of multiple metastases, particularly multiple metastases to the brain, is a contraindication to operation. However, if the patient is in relatively good condition and an adequate neurological investigation—including x-ray studies of the skull and chest, a radioactive brain scan, and cerebral angiography—reveals the presence of only one metastatic lesion in the brain and if the patient is in good condition, the tumor usually should be removed.

Most metastatic tumors of the brain are secondary to primary tumors of the lung. If both are demonstrated, the question often arises as to which should be operated upon first. It has been our practice to first remove the tumor from the brain. Then if the patient's condition is good enough to warrant another operation, the tumor in the lung may be removed or treated by radiation.

The location of the single metastasis is not a deterrent to operation if the tumor is in a location from which it can be satisfactorily removed. Obviously tumors of the brain stem, basal ganglia, and thalamus must ordinarily be considered inoperable. But tumors of the cerebellum or of the cerebral hemispheres can be satisfactorily removed. Some would exclude from the operable category those patients

with aphasia or a right hemiparesis or hemiplegia. This is wrong. Many years ago Bailey (1924) reported a case of Cushing's disease which clearly indicated this fact. A 65-year-old man with a global aphasia and a right hemiplegia had a metastatic tumor from the adrenal removed. Subsequently he recovered from his aphasia and hemiplegia and returned to work. The following case presents similar evidence supporting this point.

Case 1. This 52-year-old man was a professor of dentistry. Since 1951 it had been known that he had a mass lesion in the apex of his right lung. This was treated as a granuloma. In July 1954 he developed difficulty in speaking, writing, and reading and had two attacks of headache. He was admitted to the hospital in August 1954, at which time he had an incomplete global aphasia, a right attention homonymous hemianopia, disturbed sensibility in his right hand, and increased tendon reflexes on the right side. At operation a metastatic squamous cell carcinoma was extensively removed from the left angular gyrus. Thereafter, he was given x-ray therapy (4,280r) to the site of the tumor. His improvement began immediately after the operation and soon all of the objective signs of neurological dysfunction disappeared. He returned to work and performed as well as ever in the opinion of his associates. Because he knew the nature of the tumor he proceeded to put his financial and family affairs in order. He remained well for most of the next 12 months. In July 1955 he developed pain in the lumbar region, and thereafter his condition deteriorated. He died in September 1955 of extensive carcinomatous metastases especially in the retroperitoneal area. The primary tumor was found in the apex of the right lung.

The patient and his family were most appreciative of the relief from his distressing and disabling symptoms and for nearly a year of healthy existence that the operation and x-ray treatment had provided.

In other cases where severe headaches, nausea, and vomiting have been the predominant symptoms, or where the patient has suffered from severe dizziness, unsteady gait, and ataxia from a cerebellar metastasis, similar gratifying relief from symptoms has been provided by removal of the tumor followed by radiation therapy. These patients who have been miserable and incapacitated prior to treatment have also been most appreciative of the relief and the prolongation of life which has been provided. Even though one cannot hope to achieve equally favorable results in all cases, it is inexcusable to deny to even one patient the improvement which can be provided for some.

Failure to obtain improvement usually results from the presence of other metastases either in the brain or elsewhere in the body. Metastatic tumors of the brain typically push the neural tissues aside and produce their symptoms by the pressure upon the surrounding brain tissue and the edema of the brain which is often widespread in these cases. Removal of the tumor usually relieves both of these. Metastatic tumors of the brain are commonly relatively avascular at operation and are usually readily shelled out of their beds.

Another serious consideration warrants operation upon a single lesion in the brain believed to be a metastasis. It is not uncommon to be confronted by a patient who has had a primary malignant tumor —a carcinoma of the breast or bowel or uterus— removed sometime before who now presents evidence of a single tumor of the brain. It is tempting in such cases to assume that this is a metastatic tumor, and if one has a negativistic attitude toward such tumors, not to treat it adequately. Every neurosurgeon has had the experience of finding a benign curable tumor in such cases. If operation is not performed, the physician has unnecessarily and unwisely condemned that patient to paralysis and death.

Although tumors of the lung provide the source for most metastatic tumors of the brain, they may arise from almost any primary lesion—pancreas, bowel, uterus, and the like. Not all metastatic tumors are carcinomas. Sarcomas may occasionally metastasize to the brain.

Certain metastatic tumors provide a more hopeful outlook. Carcinomas of the adrenal and kidney, choriocarcinomas, and melanomas are outstanding in this respect. Recently McNeel and Leavens (1968) reported a case of metastatic melanoma involving the frontal lobe in which this is strikingly true. In their case a 46-year-old woman had a primary malignant melanoma removed from the shoulder in 1954. On two occasions in 1960 and for a third time in 1961 metastatic melanomas were removed from the left frontal lobe. She also was treated with phenylalanine mustard injected into the internal carotid artery. In September 1961 a metastatic melanoma was removed from the axilla. In May 1967 she was still well except for a mild right-sided hemiparesis and dysphasia. She was taking care of her household and functioning essentially at normal level. This woman was essentially well 13 years after the primary tumor was removed. This is a remarkable record but not an isolated one. It is also a tribute to the wisdom and tenacity of the physicians who cared for her.

Choriocarcinoma is fortunately a relatively rare tumor in European and American women, but is common in Southeast Asia. This particular tumor is peculiar in at least two respects. Metastases to the brain, like melanomatous metastases, are commonly associated with intracerebral hemorrhages at the site of the tumor. This is due to the tendencies of these tumors to invade and weaken the vascular walls. They also are remarkably responsive to surgical removal and chemotherapy. The following case illustrates both of these points.

Case 2. This 22-year-old woman gave birth to a healthy child in November 1961. In April 1962 she developed headaches, nausea, and vomiting. In late April she noted tingling and numbness of the left hand. Three days later her condition suddenly became worse. Her left leg became paralyzed and her left arm and hand markedly weakened. On admission to the hospital on that day she was lethargic and unable to cooperate. She had a left-sided hemiplegia with typical reflex changes and a questionable left-sided homonymous hemianopia. Cerebral angiography demonstrated the presence of a massive space occupying lesion in

the upper central area of the right cerebral hemisphere. An emergency operation was performed and a large intracerebral hematoma evacuated. Examination of it disclosed nothing but blood. She promptly improved and did very well until exactly one week later when she again developed a left-sided hemiplegia, became comatose, had a dilated right pupil, and a very slow pulse. An emergency operation was performed again and a second hematoma evacuated. Again exploration of the remaining cavity failed to disclose the source of the hemorrhage or any tumor. Again she did well for a week.

In mid-May the symptoms again recurred suddenly and she was reoperated upon for a third time. On this occasion after removing the hematoma, the bleeding point was localized and what was judged to be a ruptured arterial aneurysm was removed. Microscopic examination disclosed that the supposed aneurysm was in truth an aneurysm but one produced by invasion of the arterial wall by a choriocarcinoma. Pelvic examination, which had been postponed previously because of the critical condition of the patient on admission, now revealed the presence of an enlarged uterus. Treatment with methotrexate was started immediately. Improvement was slow but steady. When her condition became sufficiently improved, she was transferred to a rehabilitation center where she made further progress from her hemiplegia. For a long time she has lived mostly in a wheel chair. In November 1966 she gave birth to another healthy child. At present (August 1968)—six and one-half years after the onset—she still has a left-sided hemiplegia, but otherwise she seems to be in perfect health. She is able to get about her house by grasping convenient pieces of furniture. She takes care of her baby and does some of the household chores.

This woman's tumor appears to be completely cured. The neurological disability from which she suffers is the result of the three hemorrhages which occurred in her brain before the correct diagnosis could be made.

Unfortunately chemotherapy has not commonly produced as dramatic results with other types of tumor—certainly not with the ordinary metastatic carcinomas. However, another form of adjunctive therapy—dexamethasone—has produced dramatic temporary results in many cases both of primary and metastatic tumors of the brain. The use of this synthetic steroid has been particularly helpful in the preoperative, operative, and immediate postoperative treatment of all brain tumors. Its use in the more chronic treatment of malignant tumors of the brain, both primary and metastatic, has not been as widely appreciated. The following case is an excellent example of the more prolonged use of this drug.

Case 3. This 48-year-old woman had a hysterectomy for a carcinoma when she was 38 years old. She remained well until May 1966 when she developed headaches and weakness of her right side. An adenocarcinoma was removed from the left parietal lobe of her brain. Radiation therapy to the brain was given. She made a complete recovery and returned to her job doing office work. She continued well until March 1967 when her gait became slightly unsteady and shortly thereafter she became confused and dull mentally. She came to the office in a wheel chair.

Examination revealed the presence of papilledema, astereognosis in the right hand, and a sensory ataxia involving the right leg. She was placed on dexamethasone, 2 mg daily, and promptly improved. No other treatment was given. She became bright and alert and able to walk with only slight uncertainty. She again did her own housework. The treatment was continued and she remained well until July 1967 when she developed evidence of pulmonary metastases. She died in October 1967.

Lymphosarcomas do not commonly involve the nervous system but they may do so, and when properly treated exceptional results may be obtained. Previously we have reported on the favorable results that often may be obtained when intraspinal tumors of this general type are properly treated (Bucy & Jerva, 1962). The following case[1] illustrates the favorable result that may be obtained when the brain is involved by a tumor of this type. In this particular case one tumor was completely removed but another was seen and could not be removed. Whether these tumors are to be regarded as primary in the nervous system or metastatic is not clear but in this particular case no evidence of similar tumor elsewhere in the body was elicited.

Case 4. A 63-year-old woman developed signs of a tumor in the pons. She could not even sit up in bed, let alone walk. She had nausea and vomiting and multiple cranial nerve palsies, and ataxia of the right extremities. In November 1963 she was operated upon, and a lymphosarcoma was removed from the right cerebellar hemisphere. Another tumor mass was seen in the pons and undersurface of the cerebellum but was not removed. She was given radiation therapy. Thereafter she improved. Her nausea and vomiting disappeared as did the signs of involvement of her cranial nerves. The ataxia of her right extremities continued in a mild form. She became able to walk alone, do needle point, play the piano, and use the typewriter.

In the fall of 1967, four years after her operation, her difficulty in walking and the ataxic difficulty with her right extremities increased. She was admitted to the hospital and given a second course of radiation therapy. Thereafter any improvement was minimal. In January 1968 her walking began to deteriorate again. She was later admitted to the hospital and died in May 1968 at the age of 68 years.

Here again the value of aggressive treatment of a malignant tumor of the brain is obvious. Not only was the patient made much more comfortable, but her condition was strikingly improved, and her life was prolonged.

Involvement of the Spinal Cord

Metastatic carcinoma may involve the spinal cord directly, either by an intramedullary lesion or an extramedullary meningeal invasion, but such involvement is rare as compared to involvement of the spinal cord secondarily by a tumor which first invades the vertebra. These cases are of interest to us not only because temporary improvement or recovery may be obtained by proper treatment but also because of the emergency nature of these cases. Ordinarily the vertebra is involved for some time before the spinal cord becomes compressed. During this period the complaints are those of localized and radiating pain. The vertebra is progressively destroyed and weakened until finally it collapses. When this occurs tumor is usually extruded into the spinal canal and the spinal cord is suddenly compressed. The spinal cord does not withstand acute compression well, whether that compression be by a fracture,

an abscess, or a tumor. The sudden occurrence of paralysis as the result of compression of the spinal cord demands immediate action. The spinal cord must be decompressed as soon as possible—within hours—if the decompression is to prove beneficial. In most cases a delay of 12 hours or more will result in the paralysis remaining permanently. The following case which was presented at a neurosurgical conference at a Veterans Administration hospital is an excellent example of the results which can be obtained by proper treatment.

Case 5. In March 1968, a 58-year-old man was admitted to the hospital complaining of precordial and left scapular pain of two months duration. He had lost 20 pounds in weight. On the day of admission coughing had aggravated the pain and provoked paresthesias in his legs. On examination both legs were paralyzed, Babinski's sign was present bilaterally and there was a diminution of sensation below the 5th thoracic dermatome bilaterally. The bladder was distended and contained 1,200 ml of urine. X-ray examination of the spine revealed that the left pedicle of the 6th thoracic vertebra had been destroyed. Myelography showed a complete obstruction of the spinal subarachnoid space at T7. The patient was taken directly to the operating room where a laminectomy was performed. The bone of the 6th thoracic vertebra was partially destroyed by tumor and tumor tissue was found in the spinal canal. It was removed. Microscopic examination revealed a metastatic carcinoma thought to have probably arisen from the lung. (X-ray examination of the chest was regarded as negative for any tumor.)

Shortly after operation movement began returning to his legs. Two days later he became able to urinate normally. Ten days after the operation he became able to walk and his sensory loss had disappeared. He received x-ray therapy to the site of the tumor in the spine. His improvement continued and he became able to walk well although his gait was slightly spastic.

No one would contend that this man is cured. Undoubtedly he will have further trouble from his tumor in the future, and it will probably cause his death. However, it is much better for him to be up and about, without sensory loss and able to control his bowels and bladder, than it would be for him to be confined to bed with paralyzed legs, loss of sensation, requiring a retention catheter, and enemas, and developing infection of his urinary tract and decubitus ulcers. Again I would emphasize, however, that if such favorable results as these are to be achieved, the spinal cord must be decompressed as soon as possible, certainly within not more than a very few hours.

One type of carcinoma that commonly involves the spine and the spinal cord requires special treatment. These are the metastatic tumors secondary to carcinoma of the prostate. Here the effectiveness of castration and of hormonal therapy are well known. These should be used in addition to surgical decompression of the spinal cord. However, if the spinal cord is compressed and neurological symptoms are present, one should not rely alone on castration and hormonal therapy. To do so may well endanger recovery. The mere fact that one usually can effectively treat carcinoma of the prostate by endocrinological procedures does not alter this fact. If there is to be a satisfactory recovery, there is no time for a wait-and-see attitude.

At this time I would like to digress slightly to point out that any rapidly or suddenly developing paraplegia or quadriplegia should receive immediate attention. If it is the result of compression of the spinal cord, that cord should be decompressed within a very few hours if the optimum results are to be obtained. This is true whether the compression is due to a hematoma, an abscess, a granuloma, or a tumor. At the present time compression of the spinal cord as the result of a fracture of the vertebrae does not have as favorable an outlook. But there is reason to believe that in the near future if these injured patients are properly cared for within minutes, certainly within an hour, after the injury and the cord is decompressed and treatments now being developed experimentally are applied, we may expect a fair number of these unfortunate people to recover. Our major difficulty at this time is that there is *no place* in this country prepared to give adequate acute care to patients with injury to their spine and spinal cord. To attain the desirable results which I believe are possible, centers for such care and adequate means of rapid transportation from the place of injury must be provided.

Previously we have reported the results of treatment of lymphosarcomas involving the spinal cord (Bucy & Jerva, 1962). With these tumors much more favorable results may be obtained than with metastatic carcinoma. A number of our patients with such tumors are alive and well many years following treatment. Most of them do not develop symptoms of involvement of the spinal cord again, but they may develop involvement elsewhere particularly in the various lymph nodes. Tumors in these locations often respond favorably to additional radiation therapy.

Summary

It has been pointed out that solitary metastatic tumors of the brain in people in good condition should usually be removed and radiation therapy given. This will result in relief of symptoms and prolongation of life in most instances. This is true even if the patient has difficulty with speech and paralysis of his right extremities. With lymphosarcomas of the brain and some of the metastatic tumors—melanoma, choriocarcinoma, and carcinomas of the kidney and adrenal—even better and more prolonged results may be obtained.

Metastatic tumors of the spinal cord should be decompressed and radiation therapy given. Usually the symptoms of such a tumor develop very acutely. When that is true such compression of the spinal cord must be relieved promptly, as it must with any acute compression of the spinal cord if desirable results are to be obtained.

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CARDIOPULMONARY RESUSCITATION ON THE STREET

CASE REPORT

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NUMEROUS REPORTS of successful cardiopulmonary resuscitation within the hospital setting have been made since the introduction and application of external cardiac massage[1] and chest wall cardiac defibrillation.[2] The most recent studies reveal that of all attempts at resuscitation, excluding those in the operating room, between 12% and 15% are successful and have "long-term" survivors.[3, 4, 5] Those patients discharged alive from the hospital after one or more resuscitations are considered "long-term" survivors.

The case to be reported presents the same basic principles of resuscitation but in an unusual situation, outside the hospital. It demonstrates that immediate, aggressive ventilation and perfusion assistance in cardiopulmonary arrest can be totally effective regardless of where it is initiated.

Case Report

In mid-afternoon, March 20, 1968, an elderly gentleman was found comatose in the street next to his car. He had been observed attempting to leave his car when he suddenly collapsed and fell to the street. Almost immediately a nurse, on her way home from the hospital, arrived on the scene and initiated mouth-to-mouth breathing. A medical student arrived approximately one minute later.

The patient was cyanotic, without palpable pulses or auscultatory heart tones. His pupils were constricted and reactive to light. A healed transverse surgical scar across the lower anterior part of the neck was noted. Mouth-to-mouth respiration was continued and, after an ineffective firm thump on the anterior part of the chest, external cardiac massage was begun. Within approximately three to four minutes his respirations became spontaneous and the maintenance of an unobstructed airway was the only requirement for ventilation. Shortly thereafter, the ambulance arrived and 100% oxygen was given by mask with marked improvement in skin color. He was transferred by ambulance to the hospital emergency room. He had received continuous oxygen and cardiac massage while enroute to the hospital.

An electrocardiogram revealed ventricular fibrillation (Fig 1A). An intravenous infusion of sodium bicarbonate in dextrose and water was administered. He was given direct current shocks of 100, 100 and 200 watt-seconds respectively with the external defibrillator before conversion to an apparent idioventricular rhythm (Fig 1B). The blood pressure after conversion was 110/70 mm Hg. He regained consciousness shortly thereafter and had no gross neurological deficit except for mild confusion.

The patient was 65 years old with a medical history of a subtotal thyroidectomy for thyrotoxicosis in 1962 and an acute myocardial infarction in October 1967. Two weeks prior to this episode he had developed the signs and symptoms of myxedema. The protein-bound iodine was 1.3

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Possible Role of Carbohydrate-Induced Calciuria in Calcium Oxalate Kidney-Stone Formation

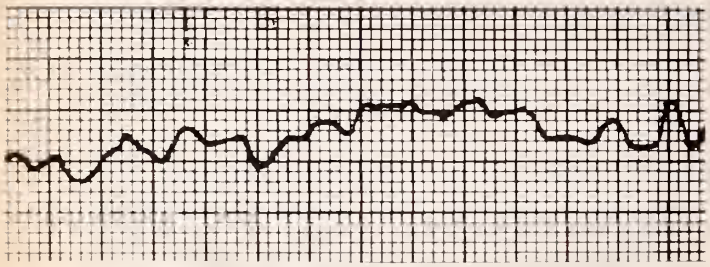
LEMANN, J., JR., PIERING, W. F., and LENNON, E. J., Marquette School of Medicine, Milwaukee, Wis.: **New Eng J Med** 280:232, 1969

Daily total urinary calcium excretion does not exceed the "normal" range in all patients who have formed calcium-containing kidney stones. Since ingestion of various nutrients augments urinary calcium excretion in normal subjects, we wondered if patients who had formed calcium stones might have an exaggerated response to nutrient ingestion. To test this, renal clearances were carried out in 11 normal subjects without personal or family history of stone, 8 patients who had formed renal calcium stones and 7 asymptomatic relatives of such patients before and after ingestion of 100 g of glucose or sucrose. Both stone patients and relatives had significantly higher rates of urinary calcium excretion in the control periods than did the normal subjects, but considerable overlap was present. After sugar ingestion each patient and relative had higher rates of calcium excretion in one or more clearance period than did any normal subject. In addition, the patients and relatives had a greater antidiuresis after these sugar loads. Thus, much higher urinary calcium concentrations were reached.

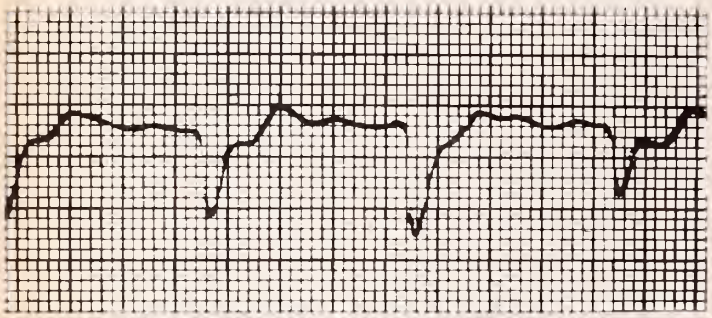
The increments in calcium excretion appeared to be the result of diminished net tubular reabsorption. The control rates of magnesium excretion and the increments in magnesium excretion after sugar were not different between groups. There were no other differences in blood or urine composition after sugar ingestion.

Coupled with higher basal rates of urinary calcium excretion, the exaggerated augmentation of calcium excretion in stone formers and relatives after carbohydrate ingestion could favor calcium precipitation. The observations in the asymptomatic relatives support the possibility of a genetic predisposition to calcium-stone formation. □

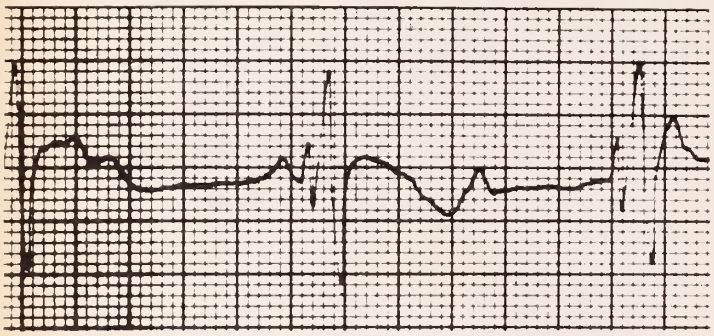
Fig. 1—Electrocardiographic history of the patient with cardiac arrest.



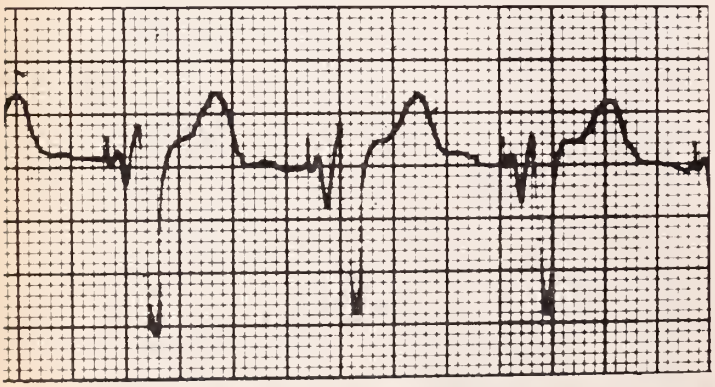
A. Ventricular fibrillation seen on hospital admission.



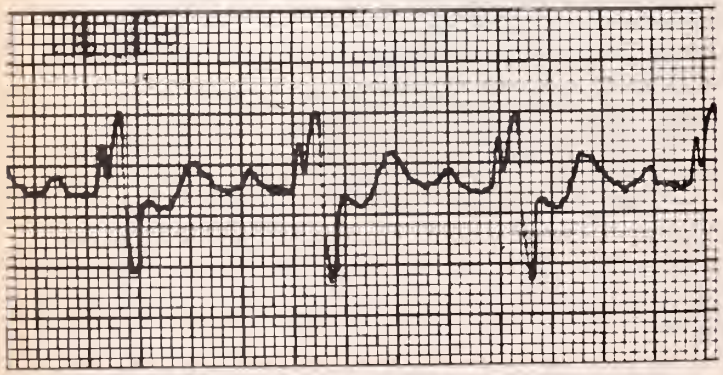
B. Idioventricular rhythm after defibrillation.



C. Complete heart block seen on admission to intensive care unit.



D. Rhythm after insertion of a transvenous pacemaker catheter.



E. Pacemaker off. Sinus rhythm with a first stage atrioventricular block and a left bundle branch block.

mcg/100 ml. His present medications included warfarin (Coumadin), digoxin, and thyroid extract. He had been seen earlier that day by his physician and was apparently doing well.

On admission to the intensive care unit, it was noted that he had a complete heart block (Fig 1C). A transvenous pacemaker catheter was inserted and his heart was paced with low voltage (Fig 1D). The pacemaker catheter was left in place for five days so that it could be used if needed. Five days later the pacemaker was removed and the patient continued to have a sinus rhythm.

It is possible that the initial episode which caused the circulatory arrest in this patient was a Stokes–Adams attack with resultant hypoxia and the ventricular arrhythmia. The hospital convalescence following resuscitation was uncomplicated and he was discharged two weeks after admission feeling quite well and without neurological deficit. He is presently 14 months post-resuscitation and doing well.

Comment

Cases of cardiopulmonary arrest, occurring outside of the hospital environment, with successful resuscitation and long-term survival are significantly few and statistical studies are impossible. However, with intensive training programs in cardiopulmonary resuscitation for nonphysician personnel, including rescue squads, police officers, firemen and the general public, there will continue to be improvement in the survival rates of these patients. Success depends upon rapid recognition of cardiorespiratory failure and the prompt restoration and maintenance of adequately oxygenated perfusion system by mouth-to-mouth breathing and external cardiac massage. This can be effectively initiated by persons unskilled in the field of medicine until trained medical assistance is available.

The studies of Johnson *et al*[4] have shown that the diagnostic categories of preexisting diseases causing cardiopulmonary failure correlate with the successful response to resuscitative measures. It is therefore possible that with proper instruction of nonmedical persons in the simple techniques of resuscitation, those persons having unexpected arrests can be salvaged both in the hospital and elsewhere.

Summary

The long-term survival without neurologic deficit after cardiopulmonary resuscitation of a patient who collapsed on the street is presented. The application of resuscitative measures outside the hospital milieu are briefly discussed.

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THERAPEUTIC DILEMMAS

COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They are published in a selective manner monthly, except January.

Editor: HARRY BECKMAN, MD, Houghton Fellow in Clinical Research and Consulting Physician, Columbia Hospital

No. 20 of a Series

CUSHING'S DISEASE

Moderator: PHILIP B. O'NEIL, MD

Participants: JOHN LENT, MD
CHARLES LOCHER, MD
ROBERT R. KOENIG, MD
DOUGLAS D. KLINK, MD
ALICE D. WATTS, MD
FREDERICK W. MADISON, MD
R. B. PITTELKOW, MD
DONALD M. WILLSON, MD
SANFORD R. MALLIN, MD

Dr. Philip B. O'Neill: This morning we will discuss the therapeutic problems that may be encountered in a typical case of Cushing's disease. Such a patient is not often cared for protractedly by practitioners who are not endocrinologists, but the evaluation of features *suggestive* of the malady is a not infrequent necessity in any type of practice. Doctor Lent will present the case.

Dr. John Lent (Resident in Medicine): A 36-year-old white woman entered the hospital with complaint of swelling of the face and weight gain during the past year and facial and body hirsutism of about 2 years' duration. There had been severe truncal acne for the past 3 years, bluish abdominal striae of more recent origin, and easy bruising, oligomenorrhea, amenorrhea, fatigue and weakness, hyperpigmentation of the axillary and perineal areas, frontal and right-sided headache of moderate severity, and blurring of vision and mental fatigue.

She had been under a psychiatrist's care because of paranoid depressive episodes during several years. She was gravida 5, para 3, having had a stillborn at 5½ months and an abortion at 6 weeks. Twins are now alive and well at 13 years. The only drugs she had been taking were meprobamate (Miltown, Equanil) and desipramine (Norpramine, Pertofrane).

The findings on physical examination were truncal and facial hirsutism and acne, truncal obesity with thin extremities, a plethoric face and "buffalo hump," hyperpigmented and velvety verrucous-like lesions in the axillary folds and perineal area, an ecchymotic area on the right upper thigh (which disappeared in the hospital), mild swelling of hands and ankles. Abdominal, pelvic and chest findings unremarkable. Blood pressure 170/100 mm Hg.

Laboratory studies disclosed the following values: hemoglobin, 15.6 gm/100 ml; hematocrit, 48%; white blood cell count (WBC) 11,800 with a normal differential; sodium, potassium, carbon dioxide, and protein-bound iodine content were within normal limits; and blood urea nitrogen, 15. An electrocardiogram showed no abnormalities. The fasting blood sugar was 154 mg/100 ml, and the glucose tolerance test showed a diabetic curve. The coagulation panel revealed a platelet 3 deficiency. X-ray findings and the adrenocortical function studies will be discussed separately.

The impression from the clinical findings and the special laboratory studies was that of Cushing's disease secondary to bilateral adrenal hyperplasia. Surgical consultation was had, and a recommended bilateral adrenalectomy, with hydrocortisone and antibiotic coverage, was performed 11 days ago without complications of any sort. The preoperative impression of bilateral adrenocortical hyperplasia was confirmed by study of the tissue sections; no evidence of tumor was found. The patient is doing well on maintenance corticosteroids.

Dr. O'Neill: Thank you, Doctor Lent. Doctor Locher will now demonstrate the x-ray findings in the patient.

Dr. Charles Locher (Resident in Radiology): There can be radiographic findings of much interest in Cushing's syndrome, but actually we do not have them in this case. I will show a representative

INVERSION OF THE LEFT HEMIDIAPHRAGM

J. D. SWINGLE, MD; R. LOGAN, MD; and J. H. JUHL, MD; Dept of Radiology, Univ of Wis, Madison, Wis: **JAMA** 208:863–864 (May 5) 1969

A large pleural effusion on the left side may invert the left hemidiaphragm so that it bulges into the upper abdomen. An inverted diaphragm is sometimes visualized on an abdominal roentgenogram and resembles a left upper quadrant mass. Two of 11 cases observed in a one-year period presented in this manner. The appearance is typical and should be suspected. The diagnosis can be confirmed by noting that the "mass" disappears following thoracentesis. Diagnostic pneumoperitoneum or pneumothorax are sometimes necessary to exclude tumors arising in the diaphragm or subphrenic abscess.

Clinical findings include severe dyspnea, which may be related to paradoxical pulmonary ventilation, and evidence of pleural fluid. If the spleen is palpable it is noted to move paradoxically since an inverted diaphragm moves paradoxically. A vague fullness may be felt in the left upper quadrant but a discrete mass, which corresponds to the one seen roentgenographically, is not palpable. □

Figure 1

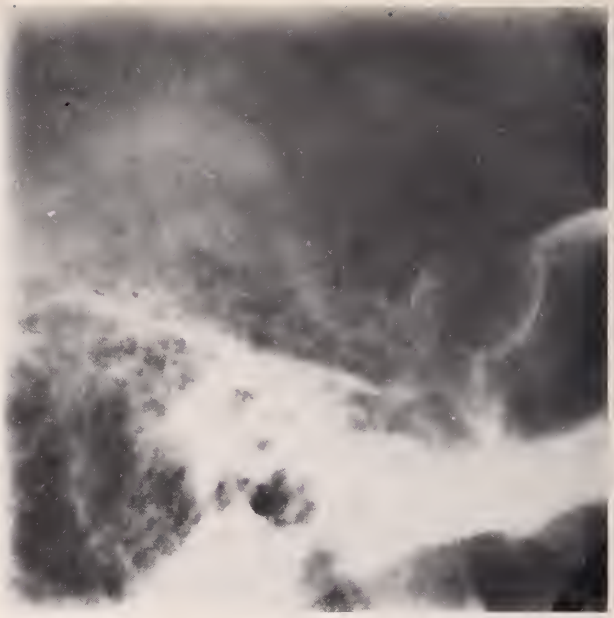


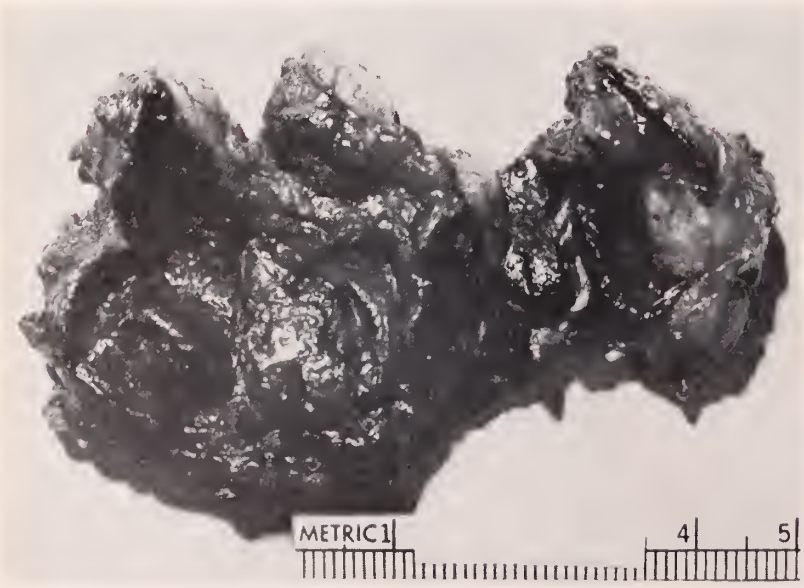
Figure 2

nephrotomogram (Fig. 1); you will see the tops of both kidneys but no evidence of adrenal glands. Since the glands were found to be hyperplastic at surgery, our examination provided no helpful information. The other film (Fig 2) is that of a coned-down view of the sella turcica; you will see that the anterior clinoids are a little sharp and pointed and less distinct than they should be. The clinical significance of this I do not know. The sella per se is not enlarged nor is it eroded or destroyed. It has sometimes been said that changes in the anterior clinoids are early findings in intrasellar tumors, but we have seen this in normal individuals. Another factor that might give this a misleading appearance is a minor degree of demineralization with associated indistinctness of the anterior clinoids; to make positive findings here one would have to do sella turcica tomography.

Dr. O'Neill: Thank you, Doctor Locher. Doctor Koenig, will you discuss the pathologic features please.

Dr. Robert R. Koenig (Department of Laboratories): We received both adrenals. The most striking feature of the left adrenal (Fig 3) was that there was cystic change associated with hemorrhage so that only the cortex remained. However, the cortex was thickened and there was one area of nodular hyperplasia. The gland weighed 17 gm (normal, 1.5–2.5) and measured about 5 cm (normal, 3.5) in greatest dimension. The right adrenal showed the same features and was of the same weight but 2 cm longer.

Figure 3



In this disease the hyperplasia occurs principally within the zona fasciculata and the zona reticularis, whereas it usually occurs within the glomerulosa in the adrenogenital syndrome. The most notable feature is the presence of numerous large vacuolated cells in the zona fasciculata. I will show you an example of this (Fig 4) from another case in which there was no hemorrhage. The more compact cells in the zona reticularis show a little yellow pigment; in consequence of this the hyper-

plasia of Cushing's disease often presents a yellow gross appearance because of the vacuolization of the lipids within the zona fasciculata cells.

Finally, here is a case that we saw a few years ago in which the syndrome was associated with a solitary adenoma (Fig 5). Adenomas occur in about 25% of the cases, this figure including the carcinomas also. Cushing's disease therefore can occur in hyperplastic, adenomatous, or carcinomatous forms.

I would like to ask whether there have been other observations of hemorrhage within the adrenal glands as in this case? I have not seen this before.

Dr. Douglas D. Klink: Not to my knowledge. Neville and Symington (*J Path Bact* 93:19–35, 1967) recently reported no evidence of hemorrhage or necrosis in 89 cases of either simple bilateral hyperplasia or nodular hyperplasia. Such findings were seen in 2 of 5 cases of benign adrenocortical tumors.

A Physician: This bleeding just may have been secondary to the surgery. I know that the point has been made in one center where primary aldosteronism is being studied that it is advisable not to catheterize the adrenal vein when looking for an adenoma because this blows up the adrenal and it may bleed.

Dr. Koenig: But this was old hemorrhage, old watery hemorrhage.

Dr. O'Neill: Thank you, Doctor Koenig. Doctor Klink saw this patient and will now expound the case and the subject in general.

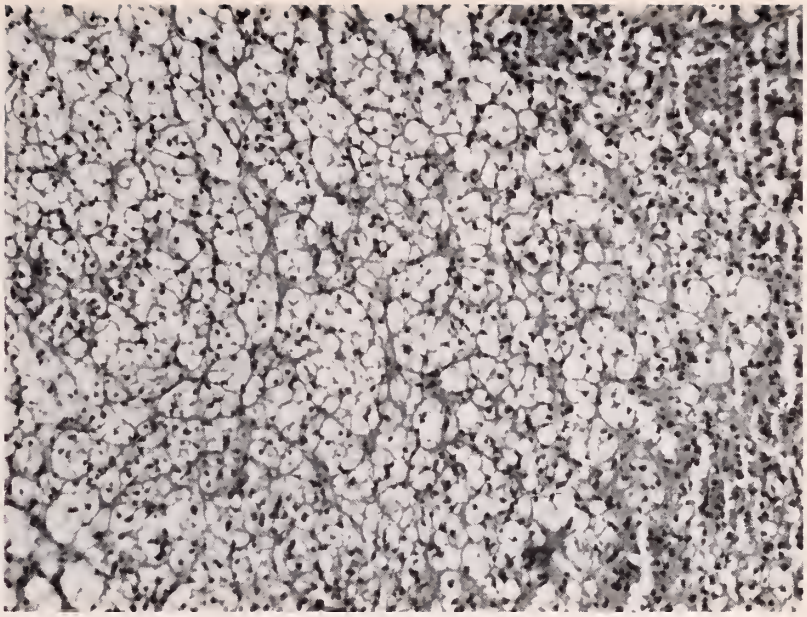


Figure 4

Dr. Klink: This is a classic case of Cushing's disease. I recall that after I first saw the patient there was no question in my mind that she had Cushing's syndrome. The problem was to identify the pathogenesis. As nearly as I could determine she had been afflicted for at least 5 and possibly 9 years. A very practical point with regard to these cases is that they are often referred by a psychiatrist who first detects the problem, as in this case. This patient had undergone quite lengthy psychiatric care, in another city before moving to Milwaukee, because her emotional problem was seriously interfering with her job and influencing her home life. The platelet factor 3 deficiency mentioned by Doctor Lent in the case history is *not* characteristic of Cushing's syndrome and was only discovered because Dr. Thomas Wall requested coagulation panels prior to surgery. Fortunately there was no operative or postoperative hemorrhage problem.

Figure 5

Here are some revealing pictures of this patient (Fig 6). The facial rounding, acne, and enlarged cervical–dorsal fat pad are apparent. There is the possibility of acanthosis nigricans shown in the underarm view. This complication has been reported several times in Cushing's syndrome, most commonly in patients with carcinoma.

Once the endocrinologist clinically suspects Cushing's syndrome, appropriate laboratory tests must be obtained to confirm the diagnosis and establish the underlying cause. These tests now consist of

Figure 6

control urinary steroid excretion studies, attempts to suppress excretion with dexamethasone, stimulate the adrenal cortex with ACTH, and indirectly stimulate the cortex by increasing endogenous pituitary ACTH release with metyrapone (Metopirone). Dexamethasone, 0.5 mg every 6 hours for two days, ordinarily suppresses 17-hydroxysteroid excretion to less than 4.0 mg/24 hours in normal patients and minimally suppresses patients with Cushing's syndrome. Dexamethasone, 2.0 mg every 6 hours, usually suppresses excretion to below 50% of control values in the presence of adrenal hyperplasia but does not suppress excretion of adenomas or carcinomas (Liddle, G. W., *J Clin Endocrinol* 20: 1539, 1560, 1960). ACTH produces an exaggerated response in patients with adrenal hyperplasia, but usually does not stimulate adenomas or carcinomas.

Recently Paris *(Proc Mayo Clinic* 39:26, 1964) found the Metopirone response helpful in differentiating hyperplasia from tumor in that tumors did not increase urinary excretion of 17-hydroxysteroids in response to the drug as did patients with hyperplasia. Plasma cortisols are now available in many hospitals and may be used in conjunction with urinary excretion studies.

The results in the case under discussion may be seen in Figure 7. Control values for both 17-hydroxysteroids and 17-ketosteroids were elevated. Dexamethasone suppression with 0.5 mg produced greater reduction in hydroxysteroid output than is classically described in patients with hyperplasia, and 2.0 mg led to even greater suppression. This demonstrates some maintenance of pituitary adrenal responsiveness. ACTH was not administered because I have not found it helpful when suppression can be produced. Metopirone produced an abrupt increase in urinary 17-hydroxysteroids far exceeding the normal doubling of control values expected. This again confirmed the maintenance of pituitary adrenal responsiveness and supported the presence of hyperplasia rather than a tumor.

Plasma cortisols at 8 AM, 4 PM, and 11 PM revealed loss of diurnal variation which is characteristic of Cushing's syndrome secondary to either hyperplasia or tumor. The 8 AM value during the second day of 2 mg dexamethasone every 6 hours revealed excellent suppression. After only 1.0 mg at midnight, however, the 8 AM value equaled 8 μg%, slightly higher than the normals reported by Pavlatos (Pavlatos, Smito, Forsham, *JAMA* 193: 720, 1965).

Now I wish to consider the therapy of Cushing's syndrome secondary to excess pituitary ACTH. This is similar to the disease as described by Cushing in 1932, which he labeled pituitary basophilism because of the presence of a basophilic adenoma in the pituitary gland. More recent studies, however,

Figure 7

STUDIES OF ADRENOCORTICAL FUNCTION BEFORE SURGERY

Period of Study	Urinary 17-Hydroxy-corticos-teroids (mg/24 hrs)	Urinary 17-Ketos-teroids (mg/24 hrs)	Urinary Creatines (Gm/24 hrs)	Plasma Cortisols (mg %)
Control	51.8	29.9	1.4	4 PM—16 11 PM—17
Third day of dexamethasone (0.5 mg/6 hrs)	23.6	20.9	1.5	8 AM—18
Third day of dexamethasone (2.0 mg/6 hrs)	9.0	9.8	1.3	8 AM—2
Control	38.7		1.3	4 PM—25
Second day of metyrapone (750 mg/4 hrs)	170.0		1.6	
Day after metyrapone	246.0		1.5	
Two weeks post-op. bilateral adrenalectomy	0.4		1.1	
Normal values	3.5-8.0		5.0-15.0	

have shown that ACTH is also produced by several other types of chromophobic cells. In fact, evidence of erosion of the sella turcica suggests the presence of a nonbasophilic tumor because basophilic adenomas are typically so small they rarely produce radiographic changes. The most frequent nonbasophilic tumor proven in the presence of sellar erosion has been a chromophobe adenoma.

There is general agreement regarding the therapy of Cushing's syndrome secondary to excess pituitary ACTH when sellar erosion is present radiologically and progressive symptoms include evidence of neurologic deficits. Under these circumstances the pituitary tumor is best approached surgically. If progression has not been rapid and, particularly, if there is no evidence of focal neurologic signs, irradiation is considered acceptable. Cobalt-60 is the most common method employed. Other radiotherapy measures are being investigated, such as alpha particle administration, yttrium-90, and cryotherapy.

There is also general agreement regarding therapy if cortisol excess has produced severe osteoporosis, marked hyperglycemia, or psychosis. Under these circumstances, bilateral adrenalectomy with removal of all adrenocortical tissue is preferred because of the certainty of cure. (Lawler, D. P. & Thorn, G. W., *Principles of Internal Medicine,* McGraw–Hill, 1966, p. 464). Particularly in this type patient, one must keep in mind that Cushing's syndrome threatens survival and a delay in effective treatment increases this risk (Danowski, T. S., *Clinical Endocrinology,* Williams & Wilkins, 1962, p. 163).

At this time there is not agreement regarding therapy of mild to moderate cases of adrenal hyperplasia secondary to excess pituitary ACTH. Though bilateral adrenalectomy offers the best opportunity for cure, the desire to avoid replacement therapy and postoperative pituitary tumors has led to more frequent attempts at pituitary destruction. Danowski *(Ibid.,* p. 163) mentions pituitary destruction as an alternative, but felt therapy should properly begin with abdominal surgery and resection of hyperplastic tissue. McKenzie (McKenzie, A. D. & McIntosh, H. W., *Am J Surg* 110:135–141, 1965), however, suggested an initial trial of pituitary irradiation in most cases because of postoperative pituitary tumor development. Lawler & Thorn *(Principles of Internal Medicine,* 1966) suggested that unilateral adrenalectomy without pituitary irradiation is acceptable only for the mildest cases and preferred unilateral adrenalectomy along with pituitary irradiation. The other adrenal was removed if symptoms recurred. External pituitary irradiation alone had produced a remission in only one third of patients treated in this manner, probably because danger to perisellar neural structures limited the maximum therapeutic dose that could be delivered *(Ibid.).* Loss of other trophic hormones also posed a problem, particularly to young women who desired future pregnancies. Liddle (Eisenstein, A. B., *The Adrenal Cortex,* Little, Brown & Company, 1967, p. 545) believes most cases of excess pituitary ACTH without sellar enlargement or neurologic deficit should be treated initially with external irradiation, reserving bilateral adrenalectomy for those that fail to respond. Adrenalectomy was preferred over more aggressive attempts at pituitary destruction.

Recently Liddle stated (personal communication) that 16 of 41 patients he had treated with external irradiation in the past 10 years continue to do well without further therapy, a success rate of approximately 40%. Remissions ranging up to 60% with Cobalt-60 have been maintained by Forsham (Williams, R. H., *Textbook of Endocrinology,* W. B. Saunders, 1968, p. 350) and Soffer reported a 70% remission rate combining unilateral adrenalectomy with pituitary irradiation *(Ibid.).*

Despite the growing interest in pituitary ablation, most centers prefer bilateral adrenalectomy for most cases of adrenal hyperplasia. Appropos the basic preference was a young lady with this condition which was diagnosed at this hospital one year ago. Pituitary irradiation was a consideration because of the mild symptoms and ability to produce some suppression, as in the case today. However, bilateral adrenalectomy was performed at the National Institutes of Health where the patient was referred to be nearer her family. Both glands were of normal size and did not reveal adenomatous change.

Subtotal adrenalectomy is no longer acceptable because of the frequent failure to achieve cure and the high recurrence rate. Raker (Raker, J. W., et al *Am J Surg* 107:153, 1964) reported that of 30 patients so treated, only 20 had initial relief and 9 of these had to be reoperated in one or two years. In a recent discussion of adrenal surgery, Egdahl also considered the procedure inadequate (Egdahl, R. H., *New Eng J Med* 278:939, 1968).

A Physician: If there is such a good chance of curing the patient through bilateral adrenalectomy, what is the basis for continuing controversy; why even consider pituitary irradiation?

Dr. Klink: There are two reasons. The first is that adrenocortical replacement therapy is not usually necessary after pituitary irradiation. The second reason is that a pituitary tumor may subsequently appear in some persons who have had bilateral adrenalectomy. Nelson was the first to point out the second possibility in 1958 (D. H. Nelson et al, *New Eng J Med* 259:161, 1958), when he reported 10 such instances. There has been ample subsequent confirmation by other observers. The frequency of this occurrence is felt to be between 5% and 15%, with onset from one to eight years after the adrenalectomy. Typically, these people become hyperpigmented because of increases in ACTH and melanocyte stimulating hormone (MSH), and the sella turcica enlarges. Operation or irradiation may not be helpful. Liddle feels he has not seen the development of pituitary tumor following primary irradiation, but

Salassa, at the Mayo Clinic (personal communication) has seen at least one such case and does not feel that primary irradiation is necessarily protective against this development. Lauler and Thorn suggest pituitary irradiation be administered if *either* pigmentation or sella enlargement develops postoperatively and further recommends prophylactic irradiation in the patient past reproductive years who undergoes bilateral adrenalectomy for hyperplasia. (Lauler, D. P., & Thorn, G. W., *Principles of Internal Medicine,* McGraw–Hill Book Co., 1966, p. 464).

Finally, there is the question of the protective value of replacement therapy after adrenalectomy. Initially it was felt that replacement therapy lowered the chance of subsequent development of a pituitary tumor. On the other hand, Salassa, in reviewing a large number of cases in 1959 (Salassa, R. M., et al *J Clin Endocrin* 19:1539, 1959), thought that it played no part and that the pituitary tumor is actually present preoperatively. Recently a case was reported in which a patient experienced marked regression of pigmentation after inadequate replacement therapy was corrected. (Hurtog, et al *J Clin Endocrin* 27:843, 1967). Thus, though most evidence negates the role of adequate replacement therapy, single case reports suggest that it may influence certain cases.

Dr. O'Neill: Thank you, Doctor Klink. Doctor Watts, you saw this patient originally; would you care to comment?

Dr. Alice D. Watts: The patient's chief complaints when I first saw her were amenorrhea, excessive hair growth, fatigue, and difficulty in opening her eyes because of the striking facial edema. We brought her into the hospital immediately for study and therapy, which was carried out by Dr. Klink.

Dr. Frederick W. Madison: As stated by Doctor Klink, the thrombopathy that was present in this case is certainly not a part of the Cushing syndrome —at least we have seen no reference in the literature to a comparable finding. Its occurrence here raises some interesting points, however. One of these is the advisability of bearing in mind always the possibility of postoperative hemorrhage seriously complicating otherwise favorable operative results. I would commend those who were in charge of this present case for having made thorough investigation of the hemostatic mechanism before entering upon the surgical procedure. Such inquiries should really be accepted as necessary preliminary steps in all complicated surgical therapy.

In the present instance coagulation studies showed an abnormal prothrombin consumption test, which suggested the possibility of a platelet deficiency of some sort. Actually the platelets were found to be quantitatively normal but incapable of functioning quite as they should. Further study revealed that the deficiency was in factor 3 and that the possibility of postoperative hemorrhage could be reasonably adequately reduced by use of platelet rich blood. In addition we had some fresh-frozen plasma, which Dr. Clara Hussey at the County General Hospital has found also effective in a situation of this sort, though the basis of its action is not quite clear. So we were doubly armed to take care of possible hemorrhagic problems in this case, thanks to a very efficiently operating coagulation laboratory.

Dr. O'Neill: Doctor Pittelkow, you examined this patient in dermatologic consultation; have you anything to add?

Dr. Robert B. Pittelkow: The hyperpigmentation in the axillary and groin regions caused Doctor Klink to ask me to see the patient, in whom we were able to confirm his suspicion of acanthosis nigricans through a biopsy and histologic study. Helen Curth, at Columbia University in New York City has deeply studied this disease. In a recent article (H. O. Curth, *Arch Dermat* 90:349, 1964) she recognizes three types: benign, malignant, and pseudo. The chief etiologic factor in the benign cases may be an hereditary one, in the malignant cases the cancer, and in the pseudoform cases the onset of excessive weight gain which may or may not be associated with an endocrine disorder. The course of the benign cases is usually favorable before puberty; afterward it may remain stationary or become progressive. The malignant cases follow the course of the cancer. The course of the pseudoacanthosis cases, as presented by our patient here, depends upon the nature and course of the obesity.

In a recent review of the 90 cases of acanthosis nigricans seen at the Mayo Clinic between 1935 and 1966, Brown and Winkelmann (J. Brown and R. K. Winkelmann, *Medicine* 47:33, 1968) reported 17 cases in association with malignancy—13 adenocarcinoma, 3 lymphomas, 1 squamous cell carcinoma. In 43 patients—24 females and 19 males—a common disease process could not be demonstrated, but obesity was a frequent finding. Histologically there were no differences between the malignant and benign forms.

Dr. Donald M. Willson: I was thinking a little of the historical aspect of this. Partial adrenalectomy was all the surgeon dared to do prior to the availability of replacement therapy, and remissions were only temporary. The metyrapone test, which blocks hydroxylation of carbon atom 11—the last step in the formation of cortisone by the adrenals—produces a negative feedback to the pituitary. The low-serum cortisol induces added pituitary stimulation of the adrenals and results in the tremendous increase in the 17-hydroxysteroids in the urine. It appears that a reduction in the production of the adrenal hormone, either by chemical means or by partial adrenalectomy, stimulates the function of the remaining adrenal.

It is most interesting that the pituitary fossa in some of these patients enlarges after total adrenalectomy. I wonder if the diurnal variation of cortisol secretion could be a factor here? Must replacement therapy not only be adequate but should it be ad-

ministered on a schedule to mimic the physiologic diurnal variation? Is there any evidence of the significance of such fluctuation in the feedback response of the pituitary?

Dr. Klink: I know of no evidence that attempts to mimic diurnal variation with steroid replacement which might prevent either pituitary fossa enlargement or hyperpigmentation.

Dr. Sanford R. Mallin: One must reckon with the fact that in Cushing's disease one is dealing with pituitary tissue that is not normally suppressible—it appears to be set on a higher level. There is also a decrease or loss of diurnal variation itself. Theoretically, it may be desirable to try to anticipate the diurnal ACTH production cycle, but practically I think it would be extremely difficult to accomplish.

A Physician: A few years ago there was described, I believe in the British literature, the autotransplantation of adrenal remnant to the thigh to preserve residual cortical activity. Does anyone know what came of this?

Dr. Klink: This was done in Jackson, Miss., by Hardy (J. D. Hardy *JAMA* 185:134, 1963), and also reported from England by Ledingham et al (Ledingham, J. G. G., Nabarro, J. D. N., LeQuesne, L. P., *Brit J Surg* 53:1057, 1966). Egdahl commented recently that there is no convincing evidence for effective function of any significant proportion of these grafts (Egdahl, *New Eng J Med* 278:939, 1968). I personally have had no experience with this approach to therapy.

Dr. O'Neill (summarizing): We have discussed Cushing's disease this morning principally from the standpoint of its therapeutic problems. It has been shown that while bilateral total adrenalectomy appears the treatment of choice in the cases of adrenal hyperplasia, pituitary irradiation may be given consideration in the patient with mild manifestations, no serious psychiatric complications, and evidence of suppressibility. Subtotal adrenalectomy appears no longer to be acceptable therapy. □

UNIVERSITY OF WISCONSIN RESEARCH

New Form of Vitamin D Discovered

A 44-year-old housewife was able to move her hands and arms freely for the first time in two years because of treatment with a new form of vitamin D discovered at the University of Wisconsin.

The successful treatment of the woman with the new, "active" form of the vitamin was announced in May at the annual meeting of the American Federation for Clinical Research. The announcement was made by Charles Y. C. Pak of the Endocrinology branch of the National Heart Institute, Bethesda, Md., and Prof. Hector F. DeLuca, biochemist at the University of Wisconsin, Madison.

The "active" vitamin D was discovered by a team of Wisconsin biochemists headed by DeLuca and was tested by Pak.

The woman treated was suffering from vitamin D resistant hypoparathyroidism. Her parathyroid gland had been removed to treat her for another disease. Normally, loss of the parathyroid gland can be overcome with large amounts of vitamin D to allow calcium utilization from bone and intestine.

The woman, however, developed a type of vitamin D resistance in which she could not change the common form of vitamin D into enough of the active form used by the body.

Her arms and hands were clutched, immovable, across her chest. Lack of calcium in her bloodstream had caused her muscles to become rigid.

Even massive doses of regular vitamin D did not help, for her body could not use the vitamin in that form.

DeLuca's active vitamin D, however, is thought to be the form actually used by the body. After treatment with the active vitamin, the woman showed remarkable response. She could move her arms and hands freely, and calcium levels in her bloodstream began to approach normality.

Both DeLuca and Pak expressed great satisfaction with the patient's remarkable recovery.

"We feel that the active vitamin D shows definite promise in treating diseases of this kind," said DeLuca.

Less than a year ago UW biochemists announced discovery of the "super" vitamin D, the active form of the vitamin. The active substance was extracted from the plasma of pigs which had been fed large amounts of regular vitamin D and had converted it into the active form. After determining the structure of the new compound, the scientists named it 25-hydroxycholecalciferol, or simply 25-HCC.

Research and clinical testing with the active vitamin were limited, however, by the small amounts of the compound that could be obtained from the pigs.

Recently DeLuca and his Wisconsin co-workers announced successful chemical synthesis of the active vitamin, making large amounts available for the first time.

Other recently reported achievements of the Wisconsin researchers include evidence that DeLuca's compound is the vitamin form actually used by the body, and proof of how and where in the body vitamin D is changed into the active form. Pioneering research into how vitamin D actually directs the body to absorb calcium was also announced.

DeLuca's research is supported by the National Institutes of Health and Wisconsin Alumni Research Foundation. He holds the esteemed Harry Steenbock Research Fellowship, named after the UW biochemist whose discovery of the process of ultraviolet irradiation of milk to produce vitamin D virtually eliminated rickets as a major health problem. □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Associate Professor of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

PERNICIOUS ANEMIA AND OTHER FORMS OF VITAMIN B_{12} DEFICIENCY

By ROBERT F. SCHILLING, M.D.
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THE MEGALOBLASTIC anemia, sore tongue, and neurologic lesions in patients with pernicious anemia are the result of Vitamin B_{12} deficiency which has developed because the patient is unable to absorb sufficient Vitamin B_{12} from his diet. Treatment of this deficiency by the injection of Vitamin B_{12} will cure the anemia and glossitis. The neurologic lesions may be partially or completely reversed but if they have been present for longer than something like six months or have advanced to spasticity and loss of sphincter control, the results of treatment may not be good. For this reason it is important that the physician have a high index of suspicion of pernicious anemia and other causes of Vitamin B_{12} deficiency when he sees patients with peripheral neuropathy or loss of vibratory and position sense, or both. The diagnosis of megaloblastic anemia is not difficult if one looks for oval macrocytes, aniscocytosis and multi-segmented neutrophils on the blood smear. Slight to moderate neutropenia and thrombocytopenia may be found. Examination of aspirated bone marrow will reveal megaloblastosis.

Demonstration of a low-serum level is the most direct way of establishing Vitamin B_{12} deficiency, but this information will not explain why the patient is deficient. Radioactive Vitamin B_{12} absorption tests will provide definite information about the patient's ability to absorb Vitamin B_{12}, and I believe they should be done in all patients who have megaloblastic anemia in this part of the world.

For treatment of this deficiency it is recommended that 1,000 μg of cyanocobalamin be injected intramuscularly or subcutaneously three times in the first week and once a month thereafter for the rest of the patient's life if he has pernicious anemia. If significant neurologic lesions due to Vitamin B_{12} deficiency are present, some experts favor injecting the vitamin every two weeks for the first six months of therapy. Because hydroxocobalamin binds to proteins to a greater extent than does cyanocobalamin, less of it is lost in the urine after injection of large doses, such as 1,000 μg. For this reason, the interval between injections may be longer if hydroxocobalamin is the form of Vitamin B_{12} used. I believe it is reasonable and safe to inject 1,000 μg of hydroxocobalamin every two months for maintenance therapy. Since adverse reactions to Vitamin B_{12} therapy are practically unknown, I consider it safe to allow nurses to give the injections in the patient's home or in the clinic.

Patients with neurologic lesions should also receive physical therapy because it is often helpful in shortening the period of disability.

If proper quantities are used, oral therapy of pernicious anemia is entirely satisfactory. A very small fraction of an oral dose of Vitamin B_{12} will be absorbed by diffusion even when no intrinsic factor is present. Thus, if the oral dose is large, the quantity absorbed may be sufficient to maintain body stores of the vitamin. A dose of 300 to 1,000 μg given by mouth each day will result in normal hematologic values and normal serum B_{12} levels. Such therapy should be used only in patients who can be relied upon to continue it faithfully. Folic acid should not be used concomitantly. □

Doctor Schilling is Professor of Medicine, University of Wisconsin Medical School.

GLYCERYL GUAIACOLATE: Inhibited blood platelet adhesion and aggregation in 11 healthy volunteers—suggesting the possibility that it may be of use in preventing blood clots. By Drs. Jerome L. Silverman and Harold A. Wurzel, U of Pennsylvania. —NEW RESEARCH in *American Druggist*, May 5, 1969 □

KETHOXAL: Shown to be a potent anti-virus compound when used as a topical treatment for herpes simplex infection in baby rabbits and mice—indicating that it may have potential utility in the treatment of cutaneous herpes in man. By Drs. Gerald E. Underwood, R. O. Stafford, and S. D. Weed, Upjohn, Kalamazoo, Michigan.—NEW RESEARCH in *American Druggist*, May 5, 1969 □

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EARLY RECOGNITION AND PROMPT EVALUATION OF SPINAL DEFORMITY

By WALTER P. BLOUNT, M.D., Milwaukee, Wisconsin

THE MILWAUKEE BRACE is generally accepted by orthopaedic surgeons as the first appliance in medical history to correct thoracic scolioses in growing children without operation.[1] Its effectiveness in improving a moderately severe curvature is shown in Figure 1. The cooperative girl with a skeletal age of 14 with poor posture, a curve of 50°, and the trunk shifted to the right can be given a back that looks straight with excellent posture and enduring normal function. Specific exercises[2] in a well made brace are capable of correcting considerably greater curves if the patient is still growing.

The result is still better if she appears for treatment at 13 with a 25° curve. My crusade this year as expressed in the title is for the early recognition and prompt evaluation of these deformities with prompt referral for treatment at the optimum age.

A girl with a skeletal age of more than 15 will improve her posture and appearance with such treatment but will obtain little permanent correction of the lateral curvature. The upper limit for boys is two years older.

The cooperative effort of the orthopaedic surgeons, orthotists, and other paramedical workers of Milwaukee has produced a valuable medical tool (Fig 1 B) that has been improved over the past 15 years by suggestions from orthopaedic teams from Minneapolis to Helsinki. The 1969 brace is not only efficient but more comfortable and inconspicuous (Fig 2). Orthotists have learned to make good braces and orthopaedic surgeons, to use them. The greatest difficulty at this point is that the patients are often referred for treatment a year or more too late to obtain good results.

Abbreviation of paper presented at the 128th Annual Meeting of the State Medical Society of Wisconsin, May 13–15, Milwaukee.

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Unfortunately, the beginning deformity is not noticeable under ordinary clothing. In our modern society adolescent girls are rarely seen in the nude, and significant lateral curves go unnoticed for several years. Occasionally a physician, a school nurse or a gymnasium teacher will pick up an early scoliosis, but for the most part the deformities are well developed before they are recognized.

The crusade must start by teaching the mother to look at her daughter or son at regular intervals during the growing years. After the child is inspected while standing, he must bend forward. Slight deviations such as those in Figures 3 and 4 are minimized by wishful thinking to "slight posture habits that will be outgrown." But when the bent back shows a definite rib prominence on one side, the mother is looking at a structural scoliosis. This asymmetry is the early sign of a deformity that is usually rapidly progressive. The child should be taken to the physician immediately. After two years without effective treatment, the deformity may become as bad as that of the unfortunate girl in Figure 5.

The informed physician will recognize the scoliosis by careful inspection particularly with the child in the forward bent position. He will confirm the diagnosis with an x-ray film taken in the standing position or send the child at once to an orthopaedic surgeon.

One difficulty is that the medical fraternity, including some orthopedic surgeons, is too apt to wait and watch these deformities instead of acting promptly.

Radiologists who read chest and gastrointestinal films should not stop with reporting a lateral curvature. They should push the alarm button. They, too, must join the crusade and notify the pediatrist or the generalist that they have discovered a deformity which will probably be progressive and should be

Fig. 1A—Skeletal age 14. A right convex thoracic curve with an overhang to the right and a prominence of the scapula and ribs on the right side were noticed only four months before this picture was taken. In the forward bent position the rib prominence was more noticeable.

Fig. 1B—A Milwaukee brace held the torso in the corrected position. With exercises in the brace the curvature was repeatedly corrected. The rib hump was diminished and the thoracic valley on the left side was partially filled out. The improved position was maintained by the shoulder pad which provided passive correction for the rib hump when the patient was supine. Gentle distraction was furnished by the occiput pad opposed by a closely molded pelvic girdle.

Fig. 1C—Three years later, the spine looked straight. The diminished curves were well compensated. The torso was symmetrical except for a slight residual rib hump. There was no loss of mobility and no scar.

evaluated by a medical man who is truly interested in spinal curvatures.

A 10° curve may be innocuous, but the patient must be reexamined at intervals of three months with x-ray views made in a standing position. If there is any doubt about progression, the curves should be measured accurately, preferably by the Cobb technic.[3] Succeeding x-ray films should be compared with the original. A consistent increase of 10° or 15° is an indication for prompt action. At this stage a spine can be straightened completely by the Milwaukee brace and exercises in the brace. There is every advantage and no disadvantage to starting the treatment immediately.

If the child is young and the spine is kept perfectly straight for several months, the patient may be partially weaned from the brace and wear it at night only.[4] There is almost no objection from the child to this routine.

Fig. 2—The modern brace is streamlined for comfort and efficiency. It is less objectionable to adolescents because it cannot be seen above a turtle necked sweater or a scarf. The girl has obtained a beautiful result with no bite deformity because all of the holding force is on the front of the throat. The modification is a boon to the orthodontist because it frees the jaw completely.

Fig. 3A—Asymmetry of the torso is clearly evident but the mother dismissed it as a postural habit.

Fig. 3B—She should have had the patient bend forward to bring out the rib hump which is the sign of a structural scoliosis.

Fig. 4A—A prominent hip will be observed in fitting a skirt. It must not be accepted as an individual peculiarity but recognized as the first sign of a vicious deformity which may progress rapidly.

Fig. 4B—When the child bends forward, the prominence of the transverse processes and the lower ribs on the left side are clear evidence of a structural deformity which may become catastrophic as in Figure 5.

Fig. 5—This child was taken to a chiropractor when the deformity looked like that in Figure 1. Under his "treatment" she became rapidly worse. The credulous mother was satisfied for two years by a consultation with another chiropractor who assured her that the patient was improving. There is good reason why these practitioners are not accredited—but they are good salesmen.

This poor girl required extensive bone surgery with the use of Harrington rods. This treatment could have been avoided had she come to the orthopaedic surgeon when the deformity was first noticed.

Not only the radiologist but also the pediatrist and the generalist must recognize the urgency of the situation. A delay of six months may mean an increase in the curve of 20° to 30°, some of which will never be regained without an extensive operation. Structural deformity of the vertebral bodies with wedging cannot be completely overcome by any method except during infancy and early childhood.

There is justification for the careful observation of a small curve without treatment. An infantile idiopathic scoliosis may prove to be of the resolving type and disappear spontaneously in a few months. It may, however, be a vicious progressive deformity that proves to be resistant to all treatment except

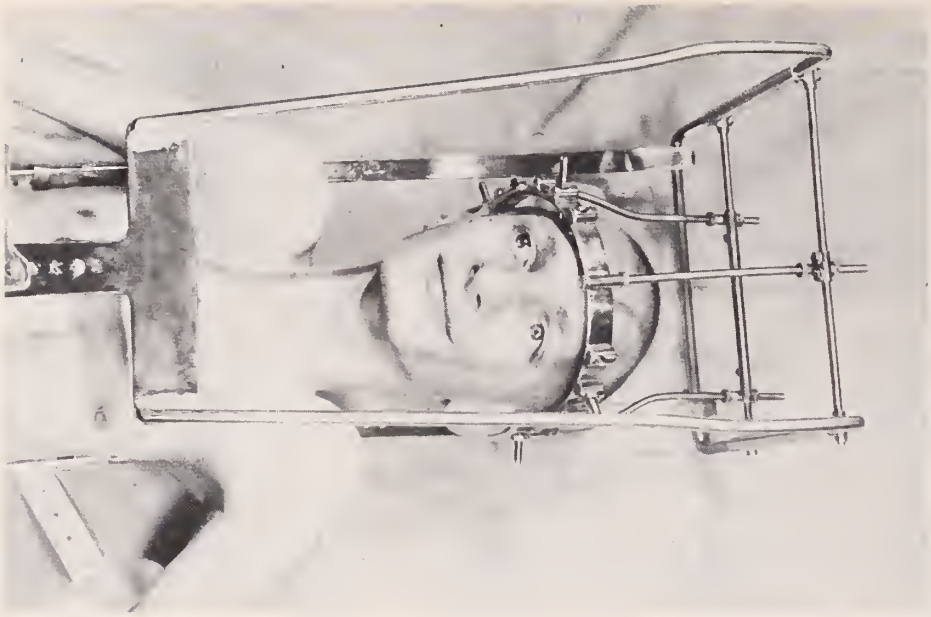

Fig. 6—Modification of the brace by the application of a halo to the upper end and a traction frame to the lower, has helped to solve the most sophisticated problems occasioned by extreme neglected deformities.

for that with the Milwaukee brace, sometimes combined with bed rest and traction. Occasionally an idiopathic scoliosis in an older child will not progress, but this is the rare exception. Most of them become worse with catastrophic rapidity during adolescent years.

Even congenital scolioses are usually progressive. The unfortunate aphorism that "congenital scolioses do not become worse" arose from the observation of a few curves with hemivertebrae. It is true that some of them remain unchanged over several years of growth, but one has no assurance that the angular deformity will not suddenly start to increase at any time, particularly during adolescence. All spinal curvatures should be carefully followed during the growing years and reexamined at intervals not exceeding six months.

The remarkable thing is that some seemingly rigid deformities can be maintained in an improved position by a Milwaukee brace. This is true particularly of the characteristic scolioses associated with von Recklinghausen's neurofibromatosis, Marfan's disease, and the rarer neuromuscular disorders.

The effective management of the more complicated scoliosis problems requires considerable experience.[5] The principles of treatment have been more clearly understood in the decade following 1958 and the technics have advanced as rapidly as those in heart surgery. Without present excellent anesthesiology and the replacement of lost blood, long segments of the spine can be fused at one sitting. We no longer rely on external fixation alone for postoperative immobilization. Scientifically engineered distraction rods aid in the correction of deformity on the operating table and the postoperative immobilization which is so important in obtaining solid fusion. Neglected curves that jeopardize respiratory function can be greatly improved by skeletal traction on the skull with distraction on the bones of the lower extremities. This sophisticated procedure may be simplified by the use of accessories to the Milwaukee brace (Fig 6). When the fusion is solid, the halo and traction frame are removed and the patient is ambulatory during convalescence in a conventional brace.

The anterior or lateral approach makes it possible to resect vertebral bodies and to graft them. Internal fixation is remarkably effective when applied anteriorly.

But all of these brilliant operative approaches to the problem are only salvage procedures. The best treatment is still the early recognition, prompt evaluation, and nonoperative treatment of the curves with the Milwaukee brace and exercises in the brace. The ultimate result is cosmetically just as good without the risk involved with operation. There is no postoperative stiffness and no scar.

If we are to avoid extensive surgical procedures and obtain the best possible result, we must reach the mothers, the pediatrists, and the generalists. The patients must come to orthopaedic surgeons early when the curvatures are small and the patients are growing. Then they will grow straight in the Milwaukee brace instead of continuing to grow more crooked.

The treatment will not be successful, however, unless the Milwaukee brace is efficient and comfortable. The orthotist who made it must be readily available to modify the brace as the patient grows and the curve patterns change. The orthopaedic surgeon must be well informed and genuinely interested in the nonoperative treatment of scoliosis. The patient must be immature and dedicated to correcting the deformity. The parents must be cooperative and not too permissive.

In recent years we have found that better results are obtained more rapidly when the patient performs specific exercises in the brace under the direction of a specially trained physical therapist.[2] Finally it is important that the patient be examined by an orthodontist at the start of the scoliosis treatment. The modern brace (Fig 2) does not cause any jaw or bite deformity. It is important that a record be made of the condition of the teeth before treatment is begun. The brace should not be blamed for preexisting deformities. Orthodontic treatment that was in progress can be continued while the patient wears the brace.

If these requirements are met and treatment started before the patients are mature, more than 50% of the spinal curves that have previously required operative treatment will improve with the Milwaukee brace and exercises in the brace so that cosmetically acceptable and normally functioning backs are obtained without operation.

Summary

All young children with scolioses of any etiology and particularly adolescents with moderately severe idiopathic curves and Scheuermann's round back should be treated with a Milwaukee brace and exercises in the brace. If good braces are available and treatment is started early, the results will usually be excellent. If parents and physicians learn about this and send patients to well informed orthopaedic surgeons promptly while the curves are still small, operations will be necessary only for neglected patients and a few stubbornly progressive curves.

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LUNG BIOPSIES OF PIGEON BREEDERS' DISEASE

G. T. HENSLEY, MD, J. C. GARANCIS, MD, G. D. CHERAYIL, MD, and J. N. FINK, MD, Marquette School of Medicine, Milwaukee, Wis.: **Arch of Path** 87: 572–579 (June) 1969

Pigeon breeders' disease is another of the growing number of biologic dust diseases of lung that have been recognized since the delineation of farmers' lung syndrome. The clinical condition is marked by fever, chills, dyspnea, and myalgia occurring 4 to 6 hours after exposure to materials associated with pigeons or, less commonly, other species of birds. The sera of patients contain high titres of precipitating antibody against offending materials. Ordinarily, the disease subsides without permanent damage to lung tissue if the patient avoids exposure to pigeons.

The authors report the results of morphologic and chemical analysis of biopsies of 2 patients, one with acute lesion and one with severe chronic disease, and compare them with 3 previously reported morphologic studies of acute lesions. It was found that the acute lesion contained distinctive aggregates of foam cells within the interstitium as well as the usual form of interstitial pneumonia. While primarily interstitial, the foam cell lesions were associated with finding of moderate numbers of foamy cells in alveolar spaces and bronchioles. In the chronic case the lung showed an obliterating bronchiolitis, and well developed interstitial fibrosis was found. This correlated with clinical function studies that demonstrated high grade obstruction. Electron microscopy revealed morphologic similarities between alveolar phagocytic pneumocytes and interstitial cells. The findings suggest that the foam cell aggregates are derived from phagocytic pneumocytes incorporated into the interstitium.

The clinical and serologic features of this disease are sufficiently well defined that, in the future, biospies will probably not be required for diagnosis. All of the previously reported biopsies of the acute lesion have shown the distinctive interstitial foam cell aggregates. It appears that the pathologic process in the lung is a chronic interstitial pneumonia modified by an inordinate reaction of phagocytic pneumocytes. The basis for this unusual feature is unknown. It is suggested that if biopsies of lung in this disease are undertaken in the future, the methods of lipid chemistry may provide insight into the nature of the process. □

FROM THE LITERATURE

In patients with hyperglyceridemia and abnormal carbohydrate metabolism, fatty acid levels may be reduced, while stable weight is maintained, and moderate reduction in blood glucose achieved by insulin or oral drug therapy. Such treatment may benefit asymptomatic patients with high fatty acid, glucose and insulin levels, and even diabetics with relatively normal insulin levels. It may decrease incidence of vascular disease in diabetics, though the latter effect remains hypothetical.—Robert I. Levy, et al., *Arch. Intern. Med.*, March, 1969. □

DIAGNOSIS AND SURGERY OF TWO ADRENAL MASSES

By WERNER A. HAUSCHILD, M.D.
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THE DIAGNOSTIC approach to the discovery of an unusual adrenal mass and the subsequent treatment are reported in the following two cases.

Case 1. A 34-year-old married woman, with two children, was admitted to the hospital complaining of pain in the right upper quadrant of the abdomen. She had noticed the pain for the first time two weeks previously when her husband hugged her, and it had recurred frequently. The pain continued to increase to a degree that made it difficult for her to bend over. She stated that the upper part of her abdomen had become enlarged during the past year but she attributed this to "middle-age spread."

The upper part of the abdomen was tender and she had fullness in the right upper quadrant which was tentatively interpreted as an enlarged gallbladder or kidney. Laboratory findings were normal, with the exception of 9% eosinophils in the differential white blood cell count.

Initial roentgenograms revealed multiple calcifications in the right upper quadrant and projected the gallbladder over the spine, displaced to the midline. The superior pole of the right kidney appeared depressed (Fig 1). A chest x-ray film and gastrointestinal series were essentially normal.

Liver scanning revealed a somewhat diminished uptake of radioactive gold in the lateral portion of the right lobe of the liver. A marked failure of uptake in the posterior region was visualized on the lateral film (Fig 2).

Presacral air insufflation and tomography in the frontal (Fig 3) and sagittal planes demonstrated a large kidney-shaped mass posterior to the right lobe of the liver, matching the area of decreased uptake on the liver scan.

The patient was operated upon March 26, 1968, with a preoperative diagnosis of a retrohepatic, retroperitoneal mass, probably adrenal. Exploration of the abdomen through a right upper paramedian incision disclosed a large adrenal cyst which was further exposed by thoracic extension of the incision and by division of the diaphragm (Fig 4).

Remnants of adrenal tissue were found within the inferior-medial cyst wall and were preserved. One larger vein between cyst wall and the inferior vena cava was ligated and divided. The entire cyst was removed after the adrenal remnant on the inferior-medial portion was sharply dissected away. The blood supply of the remaining adrenal tissue, though still connected to perirenal structures, was somewhat in question. Drainage of chest and retroperitoneum, repair of the diaphragm, and closure of chest and abdomen were carried out. The patient recovered fully without complications. Multiple calcifications were found within the wall of the adrenal cyst, as shown in x-ray film of the operative specimen (Fig 5).

Comment

Adrenal cysts are classified as (1) parasitic cysts, (2) glandular or retention cysts, (3) cystic adenomas, (4) endothelial-lymphangiomatous cysts, and (5) pseudocysts following hemorrhage.[1-6] The reported case had no epithelial lining and matches best the description of the endothelial-lymphangiomatous type.

Foster,[7] in a comprehensive review collected 220 cases of adrenal cysts (120 operative) from the world literature. The autopsy incidence was 1:1555. Eight percent were reported as occurring bilaterally. The female–male ratio was 3:1. Peripheral curvilinear calcifications were and are regarded as rather typical. Hormone studies were generally nondiagnostic.

While various roentgenologic procedures have been used for diagnosis, including tomography with presacral air insufflation, the present case appears to be the first in which a liver scan has been utilized. This procedure was decisive in conjunction with the combined review of the retroperitoneal pneumogram.

Case 2. A 54-year-old man noticed a dull, aching pain in the left upper quadrant of the abdomen and left side of the thoracolumbar area of the back in January 1968, a day after trying to start his car on a cold winter night. The pain seemed worse when he was supine and woke him at night. He felt some relief from getting up and walking around.

Two weeks later, a physical examination, barium enema, and intravenous

Fig. 1—Calcifications in the right upper quadrant and depression in the superior pole of the right kidney.

Fig. 2—Marked failure of uptake of radioactive gold in the posterior region of the liver.

Fig. 3—Retroperitoneal pneumogram showing large tumor mass on the right.

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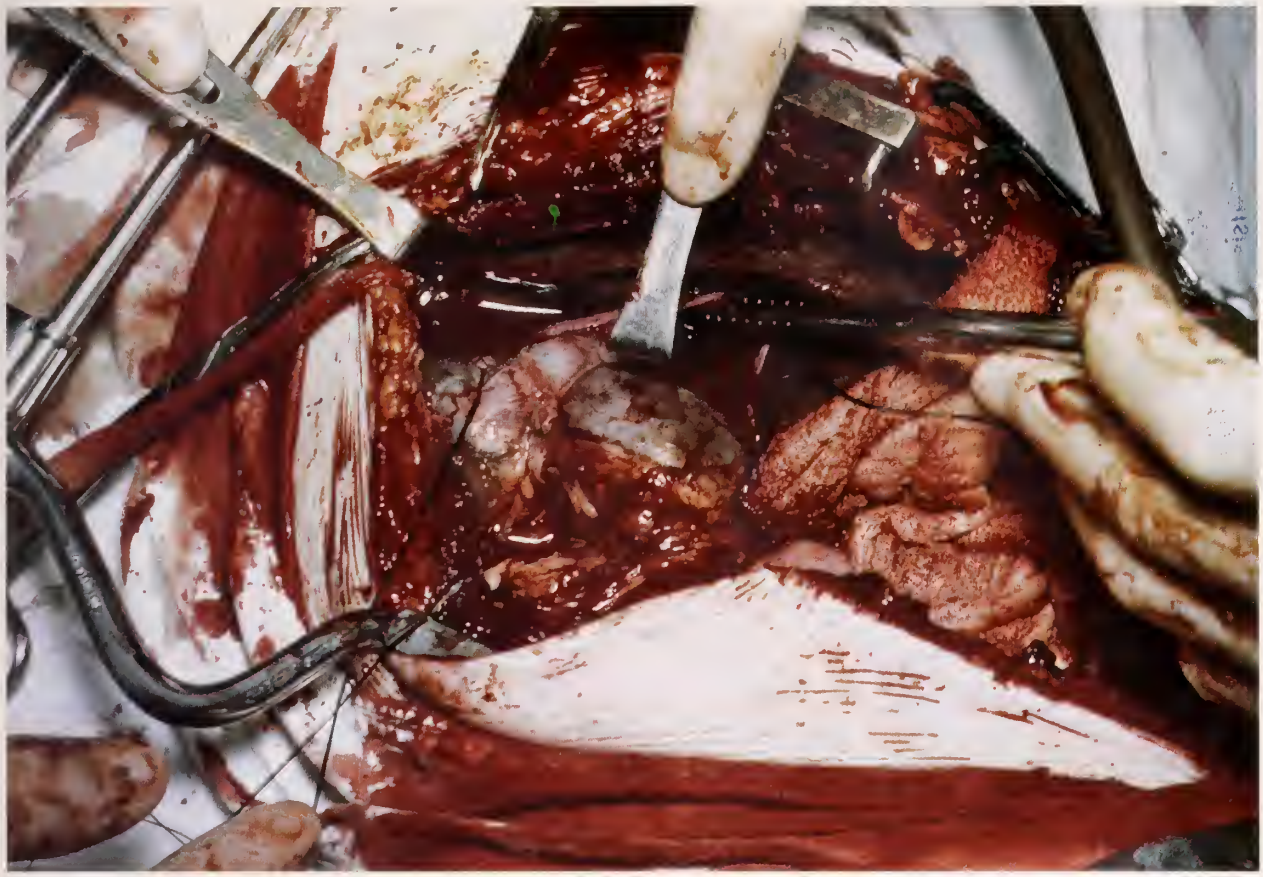

Fig. 4—Adrenal cyst posterior to the right lobe of liver and opened retroperitoneum.

pyelogram were interpreted as normal. Treatment with heat and aspirin for what was thought to be myalgia failed over a period of another two weeks. The patient was then admitted to the hospital to rule out pancreatic tumor. He denied any other specific symptoms but stated that he did not feel entirely well.

In the hospital the physical examination, cholecystogram, upper gastrointestinal series, and skeletal survey were essentially normal, but the chest x-ray film disclosed a rather sharply outlined mass anteriorly to the **right** hilus, measuring up to 4.5 cm in diameter (Fig 6) A renal arteriogram and aortogram were read as normal (Fig 7).

Bronchoscopy with biopsy from the right middle lobe bronchus and mediastinoscopy with lymph node biopsy produced no pathologic findings.

On February 12, a right-side thoracotomy was performed. A mass was found in the anterior portion of the medial segment of the middle lobe, invading the anterior segment of the upper lobe and the pericardium. No nodes were found in the subcarinal region or the mediastinum. On a frozen section, many uniform small cells were considered to be small-cell carcinoma or lymphoma. A middle lobectomy and resection of the anterior portion of the upper lobe and of mediastinal fat were performed.

Grossly, the entire specimen appeared necrotic. Histopathologic reports from four different laboratories were: (1) infarcted lymphosarcoma, (2) necrosis surrounded by nonspecific inflammatory cells, (3) leptospirosis, and (4) diagnosis uncertain.

The patient was persuaded to undergo bronchoscopy and biopsy, mediastinoscopy and biopsy, **right-sided** thoracotomy and pulmonary resection, but still the diagnosis was uncertain. His condition became worse, with more severe abdominal and back pain on the left side, general malaise, and recurring fever. On March 1 the white blood cell count was 5150 (78 segmented neutrophils, 1 eosinophils, 20 lymphocytes, 1 monocyte.) No palpable enlargement of liver, spleen, or lymph glands was found.

In a review of the x-ray findings, the left kidney was observed to be displaced laterocaudad with a density above, outlined by a wide cephaloconvex sweep of the splenic artery (Fig 7). These findings, together with the patient's pain in this area, led to the conclusion of a retroperitoneal mass.

The patient and his family still command my admiration for agreeing to an exploratory laparotomy on Mar. 6, 1968. After an upper midline incision with resection of the xiphoid process, a large tumor displacing the pancreas tail anteriorly and the left kidney caudad and to the left was felt, intimately attached to these structures and to the spleen, which was enlarged to approximately three times normal size. The liver and other abdominal organs appeared entirely normal and no enlarged lymph glands were found.

The tumor mass, left kidney, spleen, and tail of the pancreas were removed en-bloc. On gross examination, the tumor appeared to arise from within the adrenal medulla. Microscopy showed a Hodgkin's granuloma in the left adrenal gland with extension into the adjacent pancreas, and splenomegaly without evidence of Hodgkin's infiltration, probably related to blockage of venous drainage.

The patient recovered from the surgery with what appeared to be a pancreatic fistula at the drainage site in the left flank, but without serious consequences. His general condition, however, became worse in the following weeks, with nausea and recurring fever as the major symptoms. On March 19 the WBC was 13,750 (89 segmented neutrophils, 2 eosinophils, 7 lymphocytes, 2 monocytes), cephalin flocculation 24 h neg/48 h neg, SGPT 190 units, SGOT 110 units, ICD 321 units; other liver profile studies were within normal limits.

Fig. 5—Roentgenogram of collapsed adrenal cyst showing calcifications.

Fig. 6—Chest film showing pulmonary moss on the right side.

Consultation was obtained and the patient was treated with cyclophosphamide (Cytoxan). He improved within three weeks, was discharged on April 19, and remains well (July 25, 1969).

Comment

Rather unusual and dramatic procedures preceded the final diagnosis of Hodgkin's granuloma. The clinical picture and blood count prior to surgical explorations were of little diagnostic significance.

The vagary of the present case, with gross limitation of the disease to the left adrenal gland and right lung, is remarkable and concurs with Craver's statement:[8] "Literally no structure of the body is exempt from direct attack or at least from some indirect affection by Hodgkin's disease."

Our confusion with the pulmonary lesion may be excused in the light of the comment of Hinshaw and Garland:[9] "Secondary masses of lymphomatous tissue may appear in the lung proper and produce a confusing roentgenographic picture. These masses sometimes undergo degeneration with cavity formation, simulating tuberculosis and bronchogenic carcinoma."

Fig. 7—Aortogram showing laterocaudad displacement of the left kidney with a density above, outlined by a wide cephaloconvex sweep of the splenic artery.

Summary

The diagnostic procedures in discovery of two unusual adrenal masses are described.

Case 1. A large right adrenal cyst flattened the right lobe of liver against the anterior abdominal wall, resulting in the displacement of the gallbladder to the midline and depressing the upper kidney pole. Liver scanning and retropneumoperitoneum produced matching negative and positive pictures of the retroperitoneal mass.

Case 2. Upper abdominal and back pain on the left side was associated with a pulmonary mass on the right side which led to bronchoscopy, mediastinoscopy, thoracotomy with pulmonary resection of a necrotic mass, and to uncertainty about the diagnosis. Review of the aortogram brought attention to displacement of the left kidney and a density above, outlined by a wide cephaloconvex sweep of the splenic artery. Laparotomy and en-bloc resection of left kidney, spleen, and tail of pancreas revealed Hodgkin's granuloma arising from within the adrenal medulla.

Both patients recovered uneventfully.

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INTRAMURAL FIBROMA OF THE HEART

By JANE P. WU, M.D., Madison, Wisconsin

INCREASING numbers of cardiac fibromas have been reported with similar clinical and pathological pictures.[1-14] The fibromas of cardiac valves are considered to be different entities.[1] Most of the reported fibromas are in children under the age of six years with the majority occurring before age one. They occur most frequently in the left ventricular wall, while the interventricular septum is the next most frequent site.[2-6] Death usually occurs unexpectedly, and the diagnosis is seldom made antemortem.

Although primary cardiac tumors in infancy are rare, one must consider this diagnosis in an infant who has had a normal neonatal and early infancy and who subsequently develops some or all of the following symptoms: failure to gain weight, vomiting, respiratory distress, cough, cyanosis, or congestive heart failure, and the like.

Twenty-nine cases of cardiac fibromas were cited by Hoen in 1966[7] (including all the previously reported cases except for two by Wilson in 1965[1]) and one case by Osano in Japan in 1966.[8] This case will be the thirty-third in the literature.

Case Report

A four-month, three-week-old, white female infant was admitted to the hospital because of weight loss and vomiting. She was the product of a normal pregnancy and delivery. Her birth weight was 6 lbs, 2 oz. Her growth and development were normal in the first three months, but soon thereafter, she began to vomit some of her feedings and to lose weight. A milk allergy was considered, and therefore a soybean base formula was given. However, she continued to lose weight. A heart murmur was heard. Also at that time, she began to have rapid breathing, slight wheezing, and occasional cyanosis when crying. She was treated with digoxin. There was no family history of congenital heart disease.

Physical examination revealed a well developed, small infant with subcostal retractions and moderate respiratory distress. The skin was somewhat dusky, heart rate was 140 and regular, and expiratory wheezes were present in both lungs. The precordium was quite hyperactive with an apical heave and a thrill along the left sternal border. A grade V harsh ejection type systolic murmur was heard along the mid-left sternal border. The rest of the physical examination was not remarkable and the neurological examination was within normal limits. Electrocardiographic studies revealed a sinus tachycardia, an axis of 0 degree; marked left ventricular hypertrophy was evident. The chest x-ray film showed marked cardiomegaly. There were no visible calcified areas.

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Fig. 1—Cut surface of the fibroma with a rim of myocardium; the tumor has a whorled pattern resembling a uterine leiomyoma.

She was treated with antibiotics, digoxin, and meralluride (Mercuhydrin). The signs of congestive heart failure improved. Cardiac catheterization was considered, but she died rather unexpectedly on her eighth hospital day. The clinical impression was congenital heart disease with the differential diagnosis between a ventricular septal defect and a patent ductus arteriosus, each associated with moderately severe congestive heart failure, and right bronchopneumonia.

Autopsy examination of the 255-gm heart revealed a large left ventricular intramural tumor measuring 8 x 6 x 6 cm. It extended anteriorly and posteriorly, and occupied practically the entire left ventricular wall (Fig 1). The tumor was not connected with the epicardium, the endocardium, or any valves. The cut surface of the tumor was nonencapsulated, well demarcated, firm, and grayish-white, somewhat whorled and elastic, and very much resembled a uterine leiomyoma.[1,9] The left ventricle was stretched and elongated by the tumor. The tumor also involved the interventricular septum. The right ventricle was very small compared to the left ventricle. The foramen ovale and the ductus arteriosus were closed. The pulmonary artery was enlarged, measuring 1.5 cm in diameter and the aorta measured 1.0 cm in diameter. Both ovaries contained multiple small simple cysts. The rest of the autopsy was unremarkable except for generalized visceral congestion.

Histologic examination of the tumor showed mainly interlacing bundles of fibrocytes, collagen fibers, and fibroblasts (Fig 2). There were many elongated, plump cells resembling smooth muscle fibers. There were also strings and islands of striated muscle fibers (Figs 3 and 4) in the tumor, but the muscle components tended to decrease toward the center until they completely disappeared. There was no clear demarcation between the tumor and the myocardium; they tended to blend into each other. Most of the muscle fibers in the tumor had a similar appearance to the fibers of the myocardium. However, in different sections, the demarcation between the myocardium and the fibrous tumor was indistinct and the scattered striated muscle fibers infiltrated the tumor in a random fashion. Some of these fibers appeared more primitive, suggesting the possibility that they

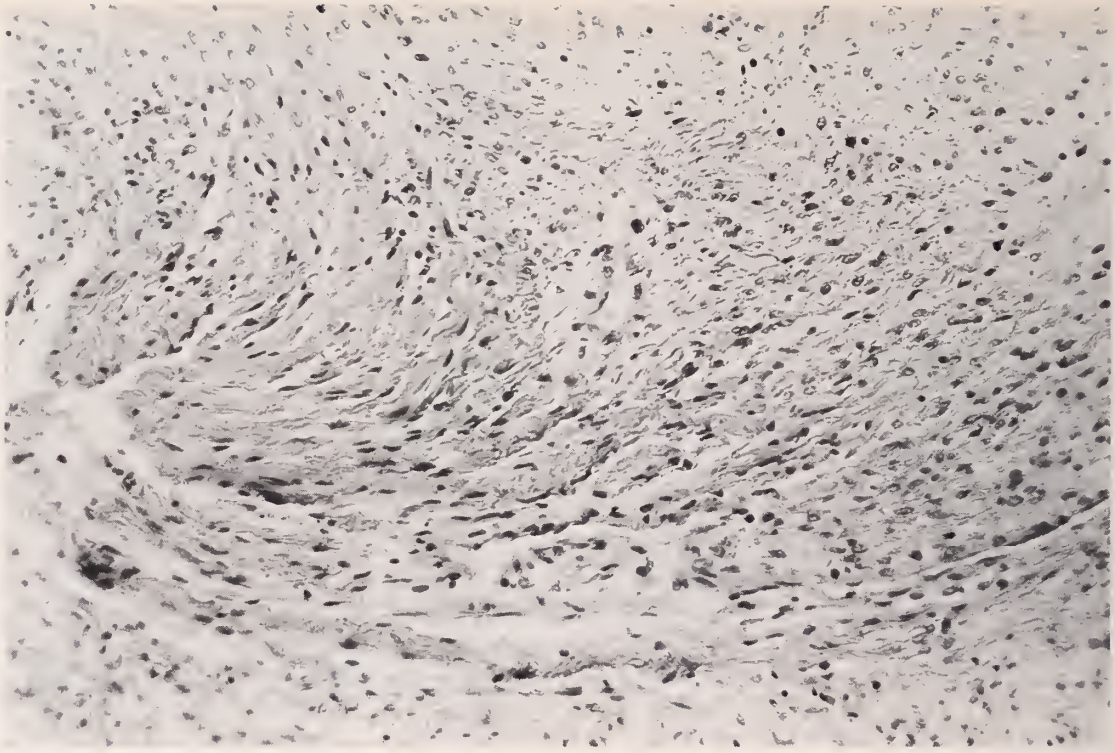

Fig. 2—Bundles of wavy collagen fibers, fibrocytes and fibroblasts, with a whorled tendency. Hematoxylin and Eosin, X250.

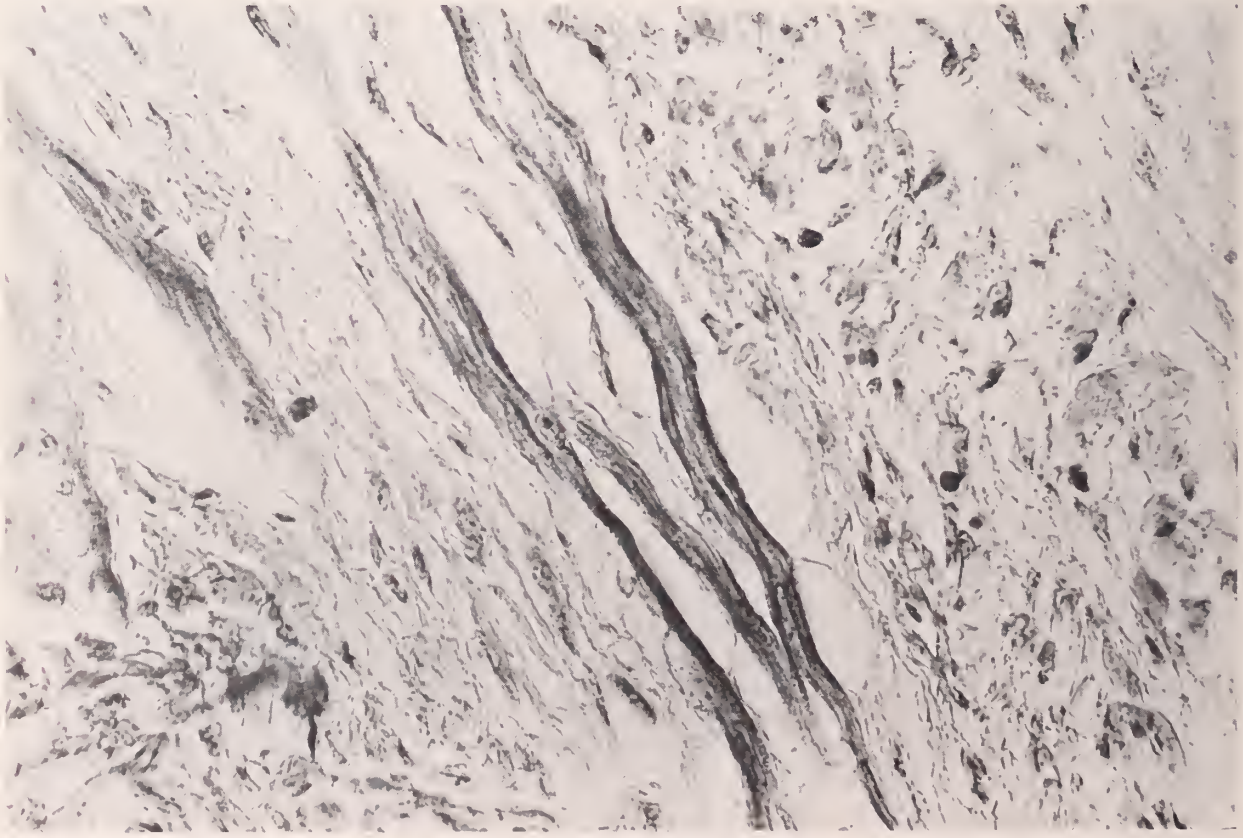

Fig. 3—Strings and islands of striated muscle fibers among the fibrous components of the tumor. Phosphotungstic acid hematoxylin stain, X600.

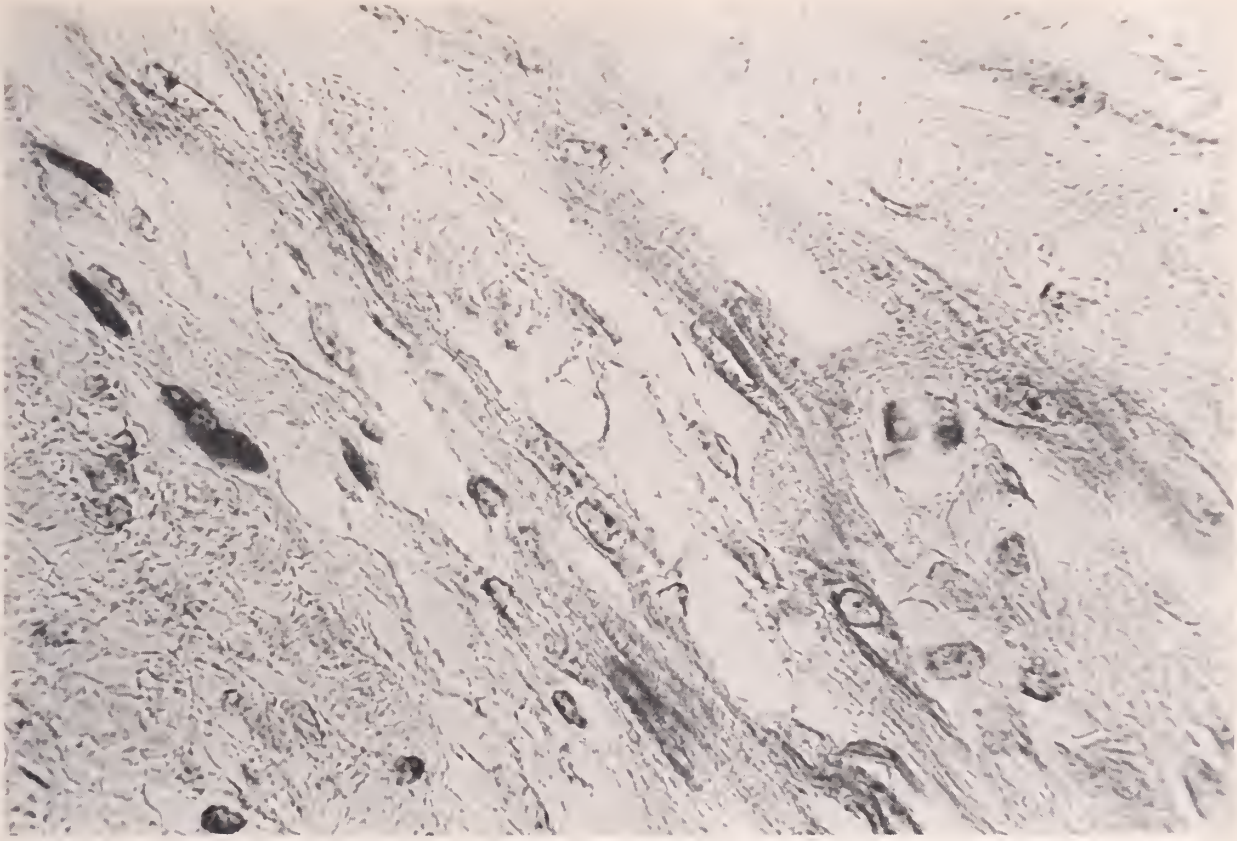

Fig. 4—Striated muscle fibers in the fibroma. Phosphotungstic acid hematoxylin stain, X1200 oil.

were a part of the tumor, rather than just trapped myocardial fibers. The cellular appearance of the tumor was not malignant. There were scattered foci of round, darkly stained cells suggestive of hematopoiesis.[1] Small calcified foci were present in the tumor. (Stains: Hematoxylin and Eosin, Phosphotungstic acid Hematoxylin, Elastic, Masson's trichome, and Periodic acid-Schiff.)

Comments

A case of primary cardiac intramural fibroma is presented. This was not diagnosed antemortem. A cardiac catheterization was planned, but the patient died unexpectedly. In a few reported cases where the diagnosis was made clinically,[1,7] in none of them was surgical excision possible. The unexpected death was probably caused by a block in the conduction mechanism associated with the intraventricular septum involvement.

Two cases of myocardial fibroma in which calcification was observed in the chest roentgenograms have been reported.[1] Several other cases of myocardial fibroma with microscopic calcification have been described.[3,7,10]

It should be kept in mind that calcification is fairly common in intramural fibromas of the heart. Angiocardiograms would be most helpful in establishing a diagnosis.

The histologic pictures of this tumor fit the descriptions of the cases reported by Bigelow et al[11] with the designation of primitive fibroma or rhabdomyofibroma. We are uncertain whether the striated muscles in the tumor are part of the neoplasm, trapped myocardial fibers, or both.

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THERAPEUTIC DILEMMAS

COLUMBIA HOSPITAL, MILWAUKEE

These ore recorded reports, which have been edited, of conferences held on Tuesdoy mornings, 8–9, involving porticipotion by members of the sloff of the hospitol, interns, residents, and guests. They ore published in o selective monner monthly, except Jonuary.

Editor: HARRY BECKMAN, MD, Houghton Fellow in Clinical Research and Consulting Physician, Columbia Hospital

No. 21 of a Series

POLYCYTHEMIA VERA

Moderator: GHOLI G. DARIEN, MD

Participants: JOHN M. KUHN, MD
DONALD SHAW, MD
GUENTHER POHLMANN, MD
RICHARD D. FRITZ, MD
ANTHONY V. PISCIOTTA, MD

Dr. Gholi G. Darien: This morning we are going to consider a malady in which there is almost an embarrassment of therapeutic riches but treatment quandaries nevertheless. Polycythemia vera responds exceedingly well to each of three modalities: phlebotomy, radioactive phosphorus, and cytoplastic agents. The therapeutic dilemma is comprised in the choice among these three. Doctor Pisciotta, a member of our Consulting Staff and Director of the Blood Research Laboratory at Milwaukee County General Hospital, will provide the principal discussion of the problem. Doctor Kuhn, will you kindly present the case?

Dr. John M. Kuhn (Resident in Medicine): A 61-year-old Caucasian nurse was admitted Mar. 28, 1967, for evaluation, principally because a hemoglobin level of 20 mg/100 ml and a hematocrit reading of 60% had been observed during a routine physical examination. Her only complaint was that she had morning headaches confined to the top of her head, which were relieved by drinking coffee. There was history, however, of phlebitis of the left leg following erysipelas in July 1966. This had responded well to anticoagulants, but since that time she had experienced paresthesias of feet and toes and felt that she fatigued too easily.

At the time of this phlebitis, a physician in another city had reported her hemoglobin level as 14 gm/100 ml. In addition there was history of pulmonary tuberculosis at age 31 and hypertension since age 30, with higher readings during the nine months immediately preceding admission; during the preceding six months there had been a weight loss of 10 lbs. One brother and one sister had died suddenly, both allegedly having had hypertension.

Her blood pressure was 160/100 mm Hg; pulse, 70 and regular. Head and neck examination revealed a nystagmus (congenital) and Grade II Keith–Wagner fundi. There was no cardiomegaly or spleno- or hepatomegaly and the lung fields were clear. The aortic component of the second heart sound was louder than the pulmonic; there were no murmurs. There was some nail-bed cyanosis. The remainder of the physical examination provided no abnormal findings.

Her hemoglobin level was 19 gm/100 ml; hematocrit reading 60%; white blood cell count, 16,690 with 74 segmenters, 1 band form, 15 lymphocytes, 5 monocytes, 4 eosinophils, and 1 basophil per 100 cells. Erythrocyte count was 6,350,000, with 1% reticulocytes. Platelet count on two occasions was 558,000 and 968,000 respectively. Sedimentation rate was 2.0. L.E. preparation was negative. Two-hour postprandial examinations yielded findings within normal limits for blood sugar, blood urea nitrogen, uric acid, calcium, and cholesterol. Total serum protein was 7.4 gm. Serum protein electrophoresis was normal and so were the protein-bound iodine and T_3 determinations, 24-hour VMA, electrolytes, and pH. There were no abnormal urinary findings. The electrocardiographic and pulmonary function studies were within normal limits; arterial oxygen saturation at rest was 90%. The leukocyte alkaline phosphatase activity was increased. Ferrokinetic studies showed marked increase in iron transport and incorporation. Serum iron was 35 mcg/100 ml; total iron-binding capacity, 375 mcg/100 ml; 9% saturation.

During the one week of hospitalization, the patient had several phlebotomies which effected disappearance of the headaches and lowered the blood pressure to 140/80 mm Hg.

Dr. Darien: Doctor Shaw, do you have a report?

Dr. Donald Shaw (Resident in Radiology): An intravenous pyelogram and a barium enema were negative, as were x-ray films of the skull and chest.

Dr. Darien: Doctor Pohlman, do you want to comment on the hematological aspects of the case?

Dr. Guenther Pohlman: Diagnosis of polycythemia vera cannot be made in the absence of demonstrated increase in red cell mass. This patient had a red cell mass of 3,435 ml, or 54.5 ml/kg, which is almost twice the normal of 32 ml/kg for her weight. Furthermore, bone marrow examination showed hyperplasia in all three cell series: erythrocytic, myelocytic, and megakaryocytic, with diminution in fat content.

We have ample evidence that there are various stages in the polycythemia process. When radioactive iron is injected, it normally disappears from the plasma in four to six hours; if one combines the disappearance half life with the serum iron concentration, the iron-turnover rate can be obtained. In this lady we found that iron was turned over more rapidly than normal but was incorporated 100% into the newly formed red cells; this is indicative of the early, uncomplicated stage of the disease.

Surface radioactivity counts are also helpful. In this patient we found evidence that the iron was appearing in the sacrum, which meant that there was active erythropoiesis going on at the normal sites. But in a later stage of the disease, particularly when treatment is by phlebotomy, the patient develops hypochromic, microcytic red cells that are liable to early hemolysis, and there is consequently a diminution of iron incorporation into red cells to a level of only 50% to 60%. In addition, as the

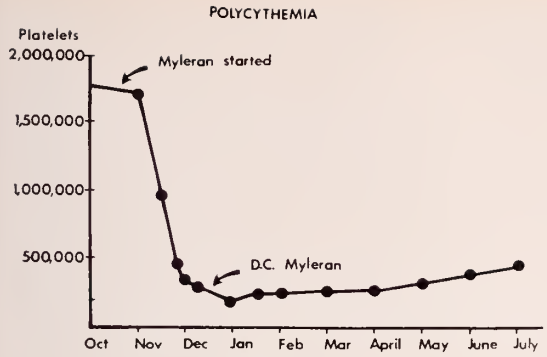

Figure 1

disease progresses, extramedullary erythropoiesis appears, and we get a pattern over the liver and spleen like that obtained earlier over the sacrum, which may progress to the point that almost all erythrocyte formation is occurring outside the normal sites. At this stage the patient will be anemic but still have high leukocyte and platelet counts, and there may be myelofibrotic replacement of the sacral marrow. Our present patient has not reached this stage.

Dr. Richard D. Fritz: I was asked to advise on the matter of therapy—whether the patient required more than just phlebotomy. Criteria have been set up by various observers on this point of when to turn to P^{32} or to busulfan (Myleran). Some say that the necessity for more than six phlebotomies a year is the indication; others that marked secondary symptoms such as gout, ulcers, post-bath pruritus, a large symptomatic spleen, thrombosis, marked bleeding, or platelet counts above 500,000 are the warning signs. But I do not think that one can follow any one of these criteria too rigidly. Our patient supplied many of the requirements but did not have an enlarged spleen. It was the high platelet counts that caused me to fear that she would wind up with a severe thrombotic or bleeding episode, and caused me to recommend more aggressive therapy.

Dr. Darien: The patient certainly did present the thrombotic threat, for wherever we introduced a needle she developed phlebitis. But she resisted the suggestion of both P^{32} or Myleran therapy until Doctor Pisciotta was finally able to persuade her to submit to the latter.

I am able to show on a chart (Fig 1) the progress of the case subsequent to institution of this therapy. In early October, about a year ago, the platelet count was 1,500,000 to 1,750,000, as you see, and the white cell count was running about 17,000, but the hemoglobin level was stable at about 14 gm/100 ml and the hematocrit reading at about 42%. At that time Myleran treatment was begun at 2 mg three times daily, with Dr. Pisciotta's advice that platelet and white cell counts be made at least once weekly. This was done until December. When the platelet count reached 900,000 we decided to reduce the Myleran to 1 mg three times daily, and very shortly the platelets dropped to 480,000 and then to 300,000. Then Myleran was discontinued. Since that time the platelets have remained at a normal level. The most recent hemogram—just this morning, Oct. 22, 1968—was hemoglobin level, 13.1 gm/100 ml; hematocrit reading, 42%; leukocytes, 5,800; and platelets, 297,000. It is amazing to me that, with no Myleran since December 1967, this patient is maintaining a normal hemogram. She is presently asymptomatic.

Dr. Anthony V. Pisciotta: The diagnosis of polycythemia vera rests upon the interaction of clinical and laboratory data, with no one finding or report supplying absolutely pathognomonic information. The question is not merely whether the patient has a high red cell count. We must determine the cause of this if he has such.

One might think of erythrocytosis, or increase in red cell count, as comparable to leukocytosis, or increase in white cell count. Many different things can cause an increase in the red count just as many different things can cause an increase in the white count. One might say, carrying the analogy further, that erythremia or polycythemia is a myeloproliferative disorder characterized by overproduction of not only red cells but also white cells and platelets; that it is, therefore, a neoplastic disease comparable to the leukemias. So we have leukocytosis, a nonspecific increase in the white count, and erythrocytosis, a nonspecific increase in the red count; and leukemia and polycythemia meaning neoplastic increases in the white cells and red cells respectively. The problem then is to distinguish between the various kinds of disorders that are characterized by a red cell increase.

Nowadays we believe that red cell production is controlled by a circulating thermostat-like substance called erythropoietin, that is produced in the juxtaglomerular body of the kidney—a small collection of epithelioid cells located near the glomerular hilus—as a reflection of hypoxia—general tissue hypoxia and hypoxia within this juxtaglomerular apparatus. Under hypoxic conditions, erythropoietin issues from the kidney into the blood stream, is carried to the bone marrow, and there effects conversion of the committed stem cell into the normoblast. From then on the completed nonnucleated red cell is produced in the familiar manner. One can turn off erythropoietin production by engendering artificial polycythemia through transfusion. Clinically, therefore, any condition characterized by hypoxia can promote increase in erythropoietin production: congenital heart disease, any hypoxic pulmonary disorder, and the like. Under such circumstances it would of course be the hypoxic disorder itself rather than the resultant increase in the red cell count that would be of paramount importance. Or there might be disturbances within the kidney itself that would result in increased erythropoietin production: carcinoma of the kidney, certain benign renal cysts, and the like. I used to think that, in the case of the renal

neoplasm, it was the increase in the number of renal cells that caused the increase in erythropoietin production, but now we know that this is not the case. It has become apparent that pressure on the renal parenchyma will in itself effect increased erythropoietin production. So then we have two mechanisms of this increased production: hypoxia and pressure on the renal parenchyma. And there is a third: fibroid tumors in the female may do it through some mechanism that is completely unknown. I did not do a pelvic examination on this lady.

Dr. Darien: It was done by Doctor Stoddard, with normal findings.

Dr. Pisciotta: So that is ruled out in our present case. Actually, I do not know of any reliable data substantiating the role of fibroids in the situation, but the possibility is generally credited. Then occasionally a cerebellar lesion, through another uncertain mechanism, may engender increased erythropoietin production. In this lady there was no such lesion. And there is one more unusual disorder characterized by hypoxia that may do it. I am referring to the malady known as the Pickwickian syndrome, which derives its name from descriptions in *Dickens' Pickwick Papers* of the fat boy Joe (it should really be called Joe's disease) who was always falling asleep. Certainly we are not dealing with this syndrome here.

How, then, do we actually make the diagnosis of polycythemia vera? In the first place there is a certain composite of clinical facts that we prefer. Post-bath pruritis is one of these. This our patient did not have, but she did complain of numbness and prickling in the fingertips—possibly the so-called Weir Mitchell syndrome or dilatation of the peripheral arterioles provoking symptoms of this sort in fingers and toes. Post-bath pruritis can be so severe at times that patients must forego hot baths or showers; there is a theory that surface-applied heat induces release of histamine by the leukocytes to effect dilatation of vessels and produce the itching. Another important symptom is a complicating full-blown gout picture, which our present patient also did not have. And then there is the matter of increased blood viscosity; the blood becomes so viscous that it cannot be pushed around adequately and the result may be syncope, headache (our patient did have headache), vertigo, and other manifestations of embarrassment in cerebral circulation.

Patients wth polycythemia are usually beet red; the mucous membranes are very dark red and the conjunctivae are almost always deeply suffused. The spleen should be enlarged, too; indeed, if it is not I have doubt of the diagnosis. However, in lieu of splenomegaly there may be hypertension, and this our patient had. There are actually two types of the disease: the splenomegalic type and the hypertensive type, the so-called Gaisbock's syndrome. In fact, however, the latter may be an altogether different disease from polycythemia vera because in it there is not only no enlargement of the spleen but also the white cell and platelet counts are not necessarily increased.

Of course the hematologic findings are very important. Everything is increased: hemoglobin level, hematocrit reading, red and white and platelet counts. An important point needs to be made regarding red cell values. Occasionally a patient will have an iron-deficiency anemia, the result of performed phlebotomies or depletion through bleeding peptic ulcers, which about 10% of these people have. The evidence for this is that there is no stainable iron in the bone marrow. If you rely on the hemoglobin alone, the diagnosis could be missed. The patient may have a hemoglobin level of 14 gm/100 ml and a hematocrit reading of 48% to 50%; but you will need a red cell count to appreciate what is really going on; a count of say 7.5 million red cells will be alerting.

Another thing we expect is elevation in white cell and platelet counts, both perhaps exemplifying the neoplastic nature of the disease. Paradoxically, the elevated platelet count may result in not only thrombosis but hemorrhage as well. Just why there is this bleeding tendency we do not know, but it is frequently present. Perhaps the platelets inhibit thromboplastin generation; there is some laboratory evidence at least that this may be the case. Another plausible explanation lies in the disproportionately small amount of fibrinogen available for the large number of red cells that must be held in the clot; fibrinogen, you will recall, is carried in the plasma, and the plasma portion of the total blood volume is reduced by the increase in the cellular portion. There is laboratory evidence of the friability of the clot in polycythemia vera: the red cell fallout test of Shirley Johnson gives a 10% figure for normals, a 50% or more figure for the polycythemic individual.

The bone marrow in polycythemia vera must reflect the observed changes in the peripheral blood; you must have a marrow crowded with everything in the typical case: normoblasts, granulocytes, megakaryocytes, and no available fat space. Doctor Pohlmann has discussed the ferrokinetics of the disease and the importance of determining the blood volume. If there is a real increase in the red cell mass this would differentiate the situation from a waste-basket type of affair called erythrocytosis of stress, which time does not permit me to discuss beyond saying that in it the plasma volume is spuriously diminished to produce an apparent polycythemia but with a normal red cell volume.

Actually, the mechanism of polycythemia vera is that of a true neoplasm. Erythropoietin is not increased and there is no hypoxia; the reason these people have polycythemia is perhaps the same reason that others have leukemia or Di Guglielmo's syndrome or myelofibrosis—because they have too many stem cells that lead to the production of red and white cells and platelets. Our clinical task, then,

is to reduce the number of these stem cells, even though we do not yet know what stimulates the production or precisely what is the stem cell that produces red and white cells.

To do this we may resort to phlebotomy to bring the hematocrit down to 45% or 50%. In order to give the patient's red cells more room in which to move about by this method, we deliberately give him an iron-deficiency anemia of course. Or we may prevent the production of stem cells, or their differentiation into functioning hematopoietic cells, through instituting depressive action against the bone marrow; that is, through resort to P^{32} or a cytotoxic agent such as busulfan (Myleran).

Should we use the radioactive agent or the cytotoxic agent? I believe it is now the consensus that the most efficient way of reducing the stem cell population is by use of P^{32}. One obtains a satisfactory remission and possibly a long period in which treatment is unnecessary. But the patient so treated has an unusually high propensity to develop terminal leukemia.

The course of polycythemia is a changing one through the years. In some patients there develops a myelofibrosis with myeloid metaplasia, and the patient ultimately burns out. But many patients die of a type of acute leukemia that resists all treatment. Even the proponents of radioactive phosphorus admit the increased tendency for the development of this leukemia in their cases, but they defend their stand by saying that the long asymptomatic span they have supplied their patients permits them to live into the leukemia period. Opponents of course say that they have simply hastened their patients' deaths. There are no firm data on either side of this rather emotional question.

The alternative therapy with busulfan (Myleran) —melaphalan (Alkeran) or pipabroman (Vercyte) could also be used—will suppress cell division in the bone marrow and also the manifestations of the disease. And the incidence of leukemia is not as high in these patients as in those treated with P^{32}. However, you do not get as good remission of symptoms with Myleran as with P^{32}. For my part, I like to take the patient's age into major consideration in connection with all the other facets of the malady in choosing between these two therapies. Other things being equal, I tend to prefer Myleran if the patient is below 65 years of age; if he is older, a true oldster with not long to live anyway, I do not hesitate in using P^{32}. I feel that in one of far advanced years it doesn't really matter whether he dies of acute leukemia or of a cerebral vascular accident. But my reasoning here may be faulty.

Dr. Darien: Thank you, Doctor Pisciotta. Are there questions?

A Physician: What would you advise if a patient with polycythemia requires surgery and is bleeding?

Dr. Pisciotta: You will have to try to learn why he is bleeding. In most instances it will be due to low fibrinogen, and you may have to give him a fibrinogen preparation to carry him through the surgery. Or the platelets may be low as a result of treatment, in which case a platelet transfusion is in order. In the main, however, it is the untreated rather than the treated patient who bleeds.

A Physician: Is there the same incidence of leukemia following spray x-ray therapy?

Dr. Pisciotta: Yes, radiation of any sort will do it, and of course Myleran and associated agents also suppress cell division and the individual's immunologic resources. Perhaps it could be successfully argued that use of any of the modalities other than phlebotomy is defeating our own purpose?

A Physician: It has been remarked here that this patient developed phlebitis at each needle puncture site. What is your explanation of such a situation?

Dr. Pisciotta: Patients with polycythemia vera have an increased tendency to develop thrombophlebitis. I really don't know the reason but could speculate that it may be due to a basic abnormality in their blood vessels.

A Physician: If hypoxia is the stimulus to erythropoietin production, why do not all hypoxic patients develop polycythemia vera?

Dr. Pisciotta: I do not know.

Dr. Darien (summarizing): Our conference this morning has developed many of the interesting facets of polycythemia vera and dwelt particularly upon the matter of choice between the several types of therapy—a discussion exemplifying, as many others do in these Grand Rounds, the necessity for close cooperative work between the clinical and laboratory sides. □

NEW RESEARCH . . .

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COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Associate Professor of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

PROGRESS IN KIDNEY TRANSPLANTATION

By WILLIAM A. KISKEN, M.D.
Madison, Wisconsin

HISTORY reveals that the dream of exchanging diseased for healthy organs has occupied the imagination of men for hundreds of years. The kidney, because of its ideal vascular supply in that it usually has a single artery and a single vein, has played a prominent role in attempting to fulfill this dream. As early as 1903, an experimental kidney transplant was performed in Chicago and this was followed by many others. At that time the failures were thought to be due to technical problems and it remained for Medawar[1] to define the immunologic phenomenon involved in organ transplant failure.

Many years elapsed before enterprising clinicians forged ahead to show the feasibility of clinical kidney transplantation. To date, some 1800 kidney transplants have been performed.[2] Worldwide statistics report an 80% one-year survival when sibling donors are used and a 40% to 45% one-year survival with cadaveric donor utilization. Technical failures play a very small part in these figures as most organ loss is due to the rejection phenomenon. What is the rejection phenomenon? How is it controlled? What are the predictions for its control in the future?

In the vast majority of transplant recipients, the organ rejection is due to the genetic differences between the donor and the recipient. Identical twins do not reject each other's tissues, while any other combination of individuals do reject with varying degrees of vigor. In general it can be said that siblings reject each other's tissues less vigorously than unrelated individuals. This general rule is reflected in the one-year survival figures quoted earlier where living-donor statistics are much better than cadaver-donor statistics.

In our chromosome makeup each of us has "genetic regions" that control the production of a particular substance or combination of substances whose presence on cell walls gives the cell a unique identity. These cells, which make up the various organs, including the kidney, are then recognized as foreign by any other individual except an identical twin. The recognition of this foreignness is the basis of rejection. It would make sense then if many such "genetic regions" exist in the general population, as it is believed, that a sibling pair because of common parentage has a greater probability of having the same "genetic regions" than two unrelated individuals. This indeed seems to be the case.

A question that immediately comes to mind is that if two nontwin siblings are identical for the "genetic region" that controls histocompatibility, why do they still reject each other's tissues? The answer lies in the fact that there probably is one "major region" and many "minor regions" controlling histocompatibility and even if the "major region" is identical the nonidentical "minor regions" will eventually cause rejection of the transplant. Present testing techniques are thought to measure only the "major regions."

Assuming that any organ from one individual, except that of an identical twin, placed in another individual is foreign and will be immunologically destroyed, transplantation will fail unless this rejection can be halted. In clinical transplantation, rejection is aborted by preventing the recipient from recognizing the organ as foreign. At present, this is done with the use of steroids and azathioprine (an immunosuppressive drug which is an analog of 6-mercaptopurine). The exact mechanisms of how these drugs prevent the recognition of foreign protein is not understood, but these drugs do prolong grafts in spite of genetic differences. It also has been shown in animals that rejection caused by the "minor genetic regions" is easier to prevent with drugs than that caused by the "major genetic regions."

The problem with steroids and azathioprine is the nonspecificity of their action. Not only do they suppress the host's reaction to the organ graft, but they also suppress the immune system in general and thereby expose the relatively unprotected recipient to many bacterial and viral invaders. This fact has led the investigators to seek additional avenues to prevent rejection.

It would seem that if the donor and recipient could be compared before transplantation so that the recipient would always receive a kidney from a donor who is genetically similar in terms of histocompatibility, lower doses of immunosuppressive drugs might be necessary to prevent rejection resulting in a de-

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crease in the incidence of secondary infection. Many tests have been devised to pick genetically similar individuals. Two such tests will be discussed, one of which was perfected at the University of Wisconsin.[3]

In the mixed leukocyte culture test, the potential donor and recipient cells are cultured together. One population acts as the stimulating cells and the others as the responding cells. Mitosis of the responding cell population takes place in the culture with more DNA proliferation being seen in the genetically different cultures than in the genetically similar cultures. The DNA proliferation is quantitated by measuring the incorporation of radioactive thymidine. The potential donor that stimulates the cells of the potential recipient the least is then selected, if ABO compatible, as the best donor. The beauty of the test is that it measures a total response without the necessity of dissecting each component of the response. Unfortunately it takes three to seven days to perform and this, at present, makes it impractical to use in a cadaver transplant program. It is, however, of great use in the living donor program and at the University of Wisconsin Medical Center, transplants have been done utilizing this test to pick the best donor from volunteers within a family. Thirty of 32 kidney transplant patients are living up to three years after transplantation.

The second test is a typing technique by which antigenic differences between donor and recipient are detected by monospecific antisera (this is a test not unlike that used in red blood cell typing). Although it is believed that this technique will ultimately be the test utilized to pick donor–recipient combinations because it can be performed in a matter of hours rather than days, it has not yet been perfected. Two problems exist. The first is in the production of monospecific antisera. If an antiserum fulfills the criteria of monospecificity, it will react with one and only one transplant antigen. The second problem is in the identification of all the antigens important in transplantation. With the first problem, two people could react positively to a given antiserum and if it was not monospecific could be reacting to entirely different components of the antiserum and thus test alike but be quite different regarding a particular transplant antigen. In the second problem, two people could type similarly but still have major differences not identified because of lack of an antiserum to identify that difference. Undoubtedly these problems will be rapidly solved.

This discussion only touches on two of the areas of investigation in the area of rejection control. Other problems actively being studied are: (1) the role of pre-formed antibodies in rejection [in the case of the kidney these are antibodies to the basement membrane of the glomerulus]. (2) the role of lipoprotein, and (3) the role of different minor blood groupings in rejection.

Another area of active investigation is in the production of permanent tolerance, where with one series of treatments a recipient is made tolerant to a donor organ with no immunosuppressive drugs administered after the transplant.

Finally, antilymphocyte globulin is a substance produced in horses against human lymphoid tissue and is used as an adjuvant to immunosuppressive drugs. Its effectiveness in preventing organ rejection has been acclaimed by some. With the utilization of antilymphocyte globulin it is thought that other immunosuppressive drugs can be used in smaller doses.

Through these avenues of research it is hoped that some day a patient in need of an organ can receive and maintain it without suffering either rejection or infection.

Finally, it seems that the size of the program will have a bearing on transplant survival. Some day only cadaver kidneys will be used for those who need organ grafts thereby eliminating any risk to a living donor. As mentioned earlier, there are probably many alternative genetic regions controlling histocompatibility present within the population. This means that the probability of finding two randomly chosen unrelated individuals that are genetically similar at the major genetic region is small. To overcome this statistical disadvantage, cooperative regional programs including the State of Wisconsin are being proposed. In these programs, large numbers of patients who will be tissue typed will be maintained on dialysis in many areas throughout the State. When a cadaver organ becomes available, it will be typed and compared—with computer assistance—with the types of all the patients in the State. The kidney will then be transplanted into the patient with the closest match. This type of program will undoubtedly improve the organ survival.

As mentioned earlier any two unrelated individuals randomly chosen will probably be a bad match, but if the number of possibilities of genetic regions controlling histocompatibility is not infinite (and it seems to be 10–15), the probability of finding a close match in a large pool of unrelated improves as the size of the pool increases. One can see that not only regional but also national and even international cooperation might be necessary to insure the best match of a kidney transplant.

As typing organ preservation and immunosuppression improve, rejection will undoubtedly become less of a problem. The State of Wisconsin with its excellent medical resources has a rich opportunity to contribute to the eventual aim of making kidney and other organ transplants therapeutic endeavors.

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PRESIDENT'S PAGE

ROBERT E. CALLAN, M. D.

UTILIZATION REVIEW

EVERYONE CONCERNED with paying for medical services today is concerned justifiably with getting full medical value for every dollar spent. The primary duty and responsibility of the physician must be the maintenance of quality medical care to the patient and secondarily the optimum use of facilities and the economic consequences of that use.

Realistically, one must accept the purchasing power of today's dollar and not expect that somehow, someway, the dollar now being spent on health care should not have suffered the same erosion and depreciation as the dollar spent elsewhere. There is little doubt but that the individual physician is in the best possible position to help his patient make the most of whatever economic resources are available to him—whether they be in the form of cash, insurance, prepayment, or taxes. We must act as wise conservators of health resources wherever possible, consistent with sound patient care.

At some point the increasing cost of health services could break the voluntary mechanism. Utilization review is but one method of combating rising health-care costs, and when properly implemented it is in the patients' best interest.

Now that the crush of increasing costs of Medicare and Medicaid make even the most pessimistic preenactment fiscal predictions appear naive, attention is diverted from the fundamental weaknesses of these programs and the galloping inflation everywhere, and is refocused on the "urgent need for the medical profession to contain costs by diligent medical utilization review." Unfortunately the problem is not quite that simple.

A utilization review plan is a fact-finding, educational instrument of the medical staff and should not have disciplinary or censuring powers. It cannot reconcile departures from proven and accepted medical practice to satisfy the financial concerns of the patient or third party payor. The physician's role in utilization review is that of an expert on medical practice, and he should confine himself to that role. The physician members, after consultation with the patient's attending physician, should make a medical decision as to the patient's condition and needs. When the medical aspect of utilization review has been accomplished, the administrative requirements should be referred to the non-physicians involved in utilization review.

Physicians are well aware of the many administrative and non-medical difficulties involved in this part of the process: determination of covered or non-covered care, skilled or supportive care, disposition problems, and financial responsibility. Most distressing of all, these important considerations are subject to change with each new directive from above. After nearly three years of operation, clearer interpretations of determining coverage of care are beginning to appear, complete with examples. Unfortunately with these new interpretations, bureaucracy must still be served: cautioning admonitions that it should be clearly understood that the examples that appear in the instructions are intended to serve as basic guidelines and do not remove the judgmental factor necessary to resolve questionable cases, and that previous memoranda are still in effect.

After having served in two hospital utilization review plans (one also serving an extended care facility in addition), some recurrent thoughts have surfaced through the bewilderment. After expressing my views of physicians' roles in such programs, it may seem a bit inconsistent that a physician should invade the realm of administration, but I consider it reciprocity.

It would seem essential that the patient and his family must be fully informed of the limitations of his medical coverage, be it private or federal insurance (Medicare), be it Medicaid, or what have you. Broadening of benefits might help reduce unnecessary and expensive hospitalization.

Utilization review certainly should not be used as a cost-control mechanism when there are no alternatives to in-hospital covered services in the contractual relationship between insurer and patient, and when coverage for such in-hospital services is not specifically labeled as contingent upon favorable utilization review.

The patient also should be aware of the functions of the required hospital and extended care facility (ECF) utilization review plans. This can be accomplished by a forthright explanatory brochure or letter given to the patient or his family on admission to the facility.

The work loads of utilization review programs are increasing rapidly, causing a great loss of med-

ical productivity of practicing physicians. Semi-retired and retired physicians would appear to be a significant source of manpower to objectively man these committees on a part-time, recompensable basis.

Upon decision by the utilization plan that a patient no longer needs in-hospital, skilled nursing home, or ECF care, it would seem logical that the appropriate responsible agency, when applicable, would be required to assume fiscal responsibility pending efforts at disposition. The time spent awaiting transfer should be properly accounted as administrative utilization rather than medical utilization.

The three-day mandatory hospitalization prior to transfer to an extended care facility is often medically unnecessary.

Some people need domiciliary facilities rather than skilled nursing homes, when home care is not a feasible alternative. For the government medical programs to financially recognize this real need would relieve the present financial pressure on the patient to qualify as "covered care."

Each physician should establish and continually review treatment and other professional decisions to assure that they are realistic and consistent with sound patient care. This would appear to be especially important in the use of physical therapy and occupational therapy in nursing homes.

The attending physician carries a great weight in utilization review—in fact, he is the key figure. Review technics and disposition recommendations without consultation with the patient's physician would seem to be ill advised from the medical as well as the legal viewpoint.

These thoughts certainly are not new and have no doubt occurred to many physicians. Utilization review is here to stay and physicians should cooperate fully to make it work.

Robert E. Callan M.D.

FDA Warns MDs Using Novobiocin

The Food and Drug Administration July 16 directed makers of the antibiotic novobiocin to recall and relabel products containing that drug and to issue a warning letter to physicians about its serious side effects.

On May 1, 1969 FDA told manufacturers to limit sharply claims for the drug and recommend its use only in the treatment of serious infections due to susceptible strains of the bacteria, *Staphyloccus aureus*. The drug is to be used only when the infection cannot be treated with other drugs and only in patients who cannot tolerate other effective antibiotics.

Certificates of safety and effectiveness for novobiocin-containing drugs were revoked July 16. Drug firms had 30 days to recall stocks of the products and to issue an appropriate letter cautioning physicians about hazards connected with novobiocin.

Certification of new stocks of novobiocin-containing drugs has been discontinued. FDA will certify lots of these drugs when they bear labeling in accord with guidelines published in the *Federal Register* July 16.

The warning to be required on the labeling says that the drug should be used only for those serious infections where other less toxic drugs are not effective or must be ruled out because of:

> . . . the high frequency of adverse reactions, including liver and blood disorders
>
> . . . the rapid and frequent development of resistant strains, especially staphylococci.

The revised labeling must also state that safer and more effective drugs are available to combat the same bacteria against which novobiocin is used.

The labeling is also to state that novobiocin's spectrum of antibacterial activity is covered by several other safer and more effective drugs.

The products directly affected by the July 16 action are:

1. *Albamycin Mix-O-Vial,* Powder for Injection; 500 milligrams of novobiocin as sodium novobiocin, per vial;
Albamycin Capsules; 250 milligrams of novobiocin, as sodium novobiocin, per capsule
Albamycin Syrup; 125 milligrams of novobiocin, as calcium novobiocin, per 5 cubic centimeters. All marketed by the Upjohn Company, Kalamazoo, Michigan, and

2. *Cathomycin Sodium Capsules,* 250 milligrams of novobiocin, as novobiocin sodium, per capsule. Marketed by Merck & Company, Incorporated, Rahway, New Jersey. □

BOOKLET RELEASED ON HYPERTENSION

Facts about hypertension are contained in a publication recently issued by the National Heart Institute. Entitled "Hypertension (High Blood Pressure)," NIH Publication No. 1714, this booklet describes how blood pressure is measured; how it is controlled; what hypertension is; the causes and diagnosis of hypertension; the drug treatment of hypertension and the effects of this treatment; and what research is being done to find the cure for hypertension. This 48-page, fully illustrated publication also contains a glossary of terms.

Copies of "Hypertension (High Blood Pressure)" (NIH Publication No. 1714) may be obtained, free of charge, by writing to the Heart Information Center, National Heart Institute, Bethesda, Maryland 20014. Quantity copies may be purchased at 50¢ each from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402. □

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Journalistic Roguery

In the uncluttered world of Bruce Nelson, reporter for the St. Cloud (Minn.) Times, women are forced to leave hospitals with their babies a bare two hours after they have delivered; hospitals receive welfare benefits for the delivery of babies, but not for post-partum care; doctors in small Wisconsin towns customarily turn away ailing children because the parents lack funds; nurses question a patient's ability to pay before they decide if he can see the doctor; a 35-year-old watch has a reasonable value of $50.00; and there is nothing unusual about taking three days to drive a distance that can be covered in slightly over five hours.

For these events are what reporter Nelson told his newspaper's readers actually occurred with the Robert Pastain family. Then, finding the story chock-full of human interest, he sold it to United Press International, which accepted the story as truth. It wasn't until the hospital that was supposed to have been involved, Sacred Heart, of Tomahawk, Wisconsin, protested to the local newspaper editor, that a full investigation of the case was started. By that time, the damage had already been done nationally, and the hospital began receiving vicious letters.

The story was given to the reporter by an itinerant calling himself Robert Pastain of Graham, Washington. He said his wife attended her mother's funeral in Flint, Michigan; her car broke down; he drove another one all the way from Washington to Michigan to pick her up; he bought a poodle dog while in Michigan for $100; enroute back to Washington, his wife began to have labor pains; they stopped a Wisconsin state trooper who escorted them to a hospital in Tomahawk, Wisconsin; his wife delivered and two hours later was discharged at the request of the hospital which told him it had no welfare facilities; he spent the next three days driving toward St. Cloud; finding himself penniless, he traded his 35-year-old watch, worth $50.00, for a tank-full of gas, worth $6.50; the baby became ill; the nurses of four physicians refused to let him see the respective doctors when it was learned he had no money to pay.

With an astonishing lack of professionalism, reporter Nelson failed to check these allegations before the story was printed in St. Cloud, before it was filed with United Press International, or even before the national news-gathering organization put it on its wires for national distribution. Subscribing newspapers across the country, which have learned to rely on the integrity of UPI, were, of course, in no position to check the story, nor should they have had to do so.

If the story had been verified before publication, its phoniness, which should have been suspected by even the most naive from a superficial review of the statements, would have been exposed. The truth of the matter is that Sacred Heart Hospital had no record of a delivery by a Mrs. Robert Pastain, on the day on which it was supposed to have

happened, or at any other time. The address given in Graham, Washington, was false; the county in which Graham was supposed to have been located is nowhere near Graham. Flint, Michigan, had no record of a death or funeral of anybody bearing the name given as that of Mrs. Pastain's mother, and there was no report filed by a Wisconsin state trooper in the Wausau, Spooner, or Eau Claire district offices of the State Highway Patrol of rendering assistance to a pregnant woman at the time it was supposed to have happened.

In short, the story was false from start to finish. The only hard facts are that someone calling himself Robert Pastain presented a woman, and a child that was born a few days previously, for medical assistance and financial aid in St. Cloud, Minnesota.

The story was false, but since it fitted reporter Nelson's vision in chiaroscuro of the good poor people and the nasty old medical profession working in cold, unfeeling hospitals, he didn't worry about the truth of the story; it simply made good copy, and that was all he was after. The possibility of maligning a fine community institution and an entire professional group didn't bother him.

The truth of the matter began coming to light when Sister Mary Girard, administrator of Sacred Heart Hospital, contacted Kenneth J. Keenan, publisher of the TOMAHAWK LEADER. He took action immediately to alert UPI as well as Associated Press, which had picked up the story, that it was suspect. His own investigation proved that Tomahawk was not involved, and as an astute newspaper man he sensed the discrepancies in the story. He immediately contacted the major news media in the area which had not already published the story advising them that the central allegation was false. Almost simultaneously UPI in Milwaukee sensed "something wrong" with the incoming wire story from its Minneapolis office. A telephone check with Tomahawk confirmed their suspicions and a stop order was issued. Happily, those editors who had not already used the original UPI version acted on this advice and "sat" on the story.

Finally, Dr. Robert E. Callan, president of the State Medical Society of Wisconsin, and Earl R. Thayer, associate secretary of the organization, launched their own independent, exhaustive investigation. In the meantime, however, both UPI and AP apologized to Publisher Keenan for not having verified the story before it was distributed.

It's a sad commentary on the tendentious quality of American journalism that a malicious story, filed by a credulous small-town reporter, should receive national publication merely because it is sensational. One would hope that the precious right of press freedom would imply an obligation for veracity. The press of the lunatic fringe can indulge itself in the manufacture of stories that fit its lunacy, but United Press International and Associated Press are the sources of most of the news disseminated in the United States today, and their reporting should not only be free of editorial bias but reasonably accurate. They were clearly taken in by the naivete of Bruce Nelson of St. Cloud. It is reassuring to learn, however, that the Wisconsin bureau of UPI and AP have expressed deep concern with the turn of events and have pledged new vigilance to prevent a recurrence.

Doctor Callan and Mr. Thayer should never have been compelled to undertake their own investigation to clear the reputation of Sacred Heart Hospital and the physicians in northwestern Wisconsin. They are to be applauded for having done so and for having revealed the falsehood of the story. Thanks to their solid documentation, the whole sorry tale was revealed as a tissue of lies.

Many falsehoods are repeated about physicians and health-care institutions; the changing attitude toward the medical profession on the part of some sections of the public demands them in order to buttress a distorted view of the character of physicians and hospitals. Unfortunately, the Pastain case isn't the last time the medical profession will be insultingly maligned as the result either of naive newspaper men or of malicious proponents of special interests. Individual physicians as well as medical organizations must keep alert to give the lie to these stories and be prepared to take prompt action to nail them down as soon as they surface in the news media. Nobody in the medical profession can afford to let them go unchallenged.—D.N.G. □

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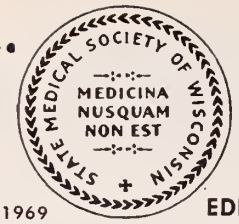
SECTION 

OPHTHALMOLOGY

AUGUST 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN EYE BANKS REORGANIZED

The Wisconsin Lions Eye Foundation has reorganized its eye banks in Wisconsin; it has created new headquarters in Madison and Milwaukee. Until recently, the Milwaukee Eye Bank had been the only official eye bank headquarters for the state of Wisconsin. By establishing a second headquarters in Madison, it is hoped that the supply of eyes suitable for corneal transplantation can be increased significantly.

The Milwaukee headquarters is now located at the Marquette School of Medicine, Department of Ophthalmology, Milwaukee County Hospital, 8700 West Wisconsin Avenue, Milwaukee 53226. Dr. Richard Schultz is the medical director; Drs. Arthur Kissling and Thomas Sawyer are associate medical directors. The secretary of the eye bank, Miss Gail Shaller, can be reached by telephone at 414/258–2040, extension 2159. Calls placed after 5 p.m. should be directed to the "ophthalmology resident on call" at Milwaukee County Hospital, 414/258–2040. A direct line to the eye bank will be installed in early September.

The Madison headquarters now assumes responsibility for the northern and western portions of the state, operating on an equal basis and with the same rules as the Milwaukee headquarters. It is located in the Eye Clinic of University Hospitals, 1300 University Avenue, Madison 53706. Dr. Guillermo de Venecia is the medical director; Drs. Matthew Davis, James Allen, and John Berger are associate medical directors. There is a 24-hour telephone service at 608/262–0564. Martha Stanbury is the eye bank secretary.

To facilitate the collection and distribution of donated eyes, substations responsible to one or the other of the headquarters have been established. The substations assigned to the Milwaukee headquarters are located in Appleton, Burlington, Cudahy, Hartford, Kenosha, Menomonee Falls, Oconomowoc, Racine, Watertown, and Waukesha. Those assigned to the Madison headquarters are Beloit, Chippewa Falls, Marshfield, Monroe, Richland Center, Shawano, Stoughton, and Wausau.

The Wisconsin Lions Eye Foundation assumes support for the Wisconsin Lions Eye Banks. The eye banks wish to thank all Lions Club members in the state; in particular, members of the Wisconsin Lions Eye Bank committee: O. J. Turck, director and chairman; David Herb, executive secretary; Hugh Scott, Tom Sheehan, Gene Brabazan, Larry Reuter, and Douglas Nehs, directors, for their time and effort. James Rundel and Dr. Robert Ainslie of the Madison Lions Club also have been very helpful.

There are about 20,000 blind people in the United States who could be helped by corneal transplantation, yet only about 2,000 of these operations are performed annually due to an insufficient supply of donated eyes. On August 1 about 37 pairs of eyes were needed in Madison and Milwaukee. The Wisconsin Lions Eye Banks are now in a position to provide eyes for corneal transplants. Physicians desiring eyes should contact the eye bank headquarters nearest them, and their names will be placed on a list of prospective recipients.

RETINA FELLOWSHIP AT U OF W

Dr. James S. Shapiro is at the University of Wisconsin for six months training in retinal detachment surgery. Doctor Shapiro graduated from the University of Nebraska Medical School and did his ophthalmology residency at Highland General Hospital, Oakland, Calif.

MEETINGS

The next meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology will be held at the Dellview Motel, Lake Delton, September 26–28. Dr. Joseph Haas, Chicago, will speak on surgical subjects and Mr. Jack Copeland, Milwaukee, will speak on optical problems. Dr. Henry Williams of Minnesota will speak on ear, nose, and throat problems.

Physicians interested in more information about this meeting or in joining this society should contact George L. McCormick, MD, Secretary, 102 East Main Street, Waukesha, Wis. 53186. Annual dues: $10.

OPHTHALMOLOGIST JOINS MONROE CLINIC

Dr. William L. Baker has joined The Monroe Clinic in Monroe. Doctor Baker graduated from Baylor University College of Medicine in Houston, Texas. He took his ophthalmology residency at Montreal General Hospital, Montreal, Quebec, Canada, from 1965 to 1968. He was in private practice in Greenville, Texas, until he recently joined The Monroe Clinic. □

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CHRONIC ULCERATIVE COLITIS AND CROHN'S DISEASE OF THE COLON

By BENJAMIN M. RUSH, M.D., Monroe, Wisconsin

THESE TWO distinct disorders—chronic ulcerative colitis and Crohn's disease of the colon—are found primarily in the lower ileum and throughout the colon.

Chronic ulcerative colitis is characterized by hyperemia of the mucosa, thickening of the muscularis, and loss of elasticity of the viscus. The mucosal surface has a skim of bloody exudate whose removal is followed by punctate bleeding that has been termed "pink sandpaper." The submucosal vessels are obscured by inflammatory changes in the mucosa. Histological examination demonstrates abscesses of the crypts of Lieberkuhn. A few cases will be marked by a pronounced vasculitis. Attempted mucosal repair of the ulcers is effected by a thin atrophic epithelium. Pseudopolyps of granulation tissue and disorganized mucosa are commonly found and true adenomatous polyps also occur.

Crohn's disease is a granulomatous process which appears to begin as a disorder of the lymphatics of the submucosa with hyperplasia and resultant blockage of lymph flow giving rise to lymphedema that is reflected by the mucosa as a cobblestone effect, and interspersed with numerous ulcerations and areas of secondary infection. There is fibrosis with thickening and rigidity of the walls, fibrotic shortening, and lymphadenopathy of the mesentery. The subserosal fatty tissue will appear to creep up over the lateral walls and this is striking in an emaciated patient. Histological examination demonstrates tubercles of epithelioid cells and multinucleated giant cells without necrosis. There are reduced numbers of goblet cells, accumulations of neutrophilic cells in abscesses, and ulceration that may extend into sinus tracts. Necrosis of lymph nodes is common with gross abscesses containing a variety of pathogenic and nonpathogenic organisms.

In order to help differentiate between the two diseases, it can be kept in mind that chronic ulcerative colitis appears to begin as a mucosal disorder and that Crohn's disease begins in submucosal or serosal lymphatics. Chronic ulcerative colitis has been more frequently reported as occurring in the rectum and granulomatous disease in the ileocecal region. However, the rectal mucosa and serosa of the ileocecum are the two most commonly visualized layers of the lower alimentary tract, and in some part this may account for the fact that early chronic ulcerative colitis is noted more often on the left and early Crohn's disease on the right.

The history of early chronic ulcerative colitis is one of increasing frequency of bowel movements, diarrheal in character, containing mucus and fresh blood. There is an increased desire to evacuate the rectal contents as soon as material is passed from the pelvic colon, followed by a sense of incomplete emptying and deep-seated rectal discomfort. If the disease remains limited to the rectum, there need be no further increase in symptoms and a periodicity established of spring and fall exacerbations. Overindulgence in alcohol or mental distress can also cause a resumption of symptomatology. The rectal mucosa between episodes may appear normal.

Early Crohn's disease is manifested by a discomfort in the right lower abdominal quadrant with minor tenderness to pressure, and the discomfort may persist for a number of days. Although the white blood cell count may or may not be elevated and signs of septic disease may or may not increase, an appendectomy is often performed. When the normal appendix has been delivered, further exploration will demonstrate a terminal ileum or cecum that

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has serosal congestion, lymphedema, loss of translucency, and mesenteric lymphadenopathy. The mucosal status at this stage of the disease is not commonly observed or biopsied. Upon recovery from the operative procedure, the symptoms may or may not abate for awhile. Usually they tend to recur without periodicity, but again psychic distress is associated with increased symptoms.

Clinical Diagnosis

After either disease has been present over a prolonged period, the symptom complexes tend to merge and the clinical differential diagnosis becomes more difficult. This is to be expected because neither is limited to an isolated segment of gut and the body responds to generalized inflammation of the intestines in a fairly small variety of ways, although these may be extremely destructive and incompatible with life. In general, the patients will be weak, lose weight, have abdominal distress, and an increasing diarrhea with marked urgency and tenesmus. Chronic ulcerative colitis produces a more profuse watery stool that contains large amounts of mucus and blood. Crohn's disease results in a more localized type of abdominal distress and colic, and the stools lack gross blood and mucus.

Abdominal examination in chronic ulcerative colitis discloses a wasting of the subcutaneous fat, the gas-distended gut is markedly tender to light pressure and auscultation reveals periods of hypoactivity followed by peristaltic rushes associated with the mass colonic reflex for evacuation. In Crohn's disease the same degree of wasting may not be present, and advanced disease in the colon can be present with minimal tenderness and no palpable organs. If internal fistulization or sinus formation has occurred, this will give inflammatory masses and muscular guarding.

Inspection of the perineum in either process may show extensive fissuring and fistulization with ragged under-cupped edges, no attempt at walling off or development of clear-cut channels, and the entire area bathed in malodorous pus.

Sigmoidoscopic examination may or may not be confirmatory. In chronic ulcerative colitis, if it is primarily manifest in the rectum, the changes described earlier will be seen. In cases where it began in the right colon the mucosa can be grossly normal. Usually if anal disease is due to chronic ulcerative colitis, the rectal mucosa will show the disease also. In Crohn's disease the granulomas are for the most part not seen through the proctoscope. Even with ulcerative anal disease there may be no granulomas found. Occasionally they are present at the internal opening of a fistula, but biopsies of these areas do not often demonstrate tubercles.

Plain films of the abdomen showing a colon distended with air is more often seen in chronic ulcerative colitis, whereas a large amount of gas in the small intestines is more often shown in terminal ileitis. Crohn's disease of the colon usually shows no alteration of the usual distribution of intestinal air.

Barium enema in chronic ulcerative colitis more frequently reveals the process beginning in the rectum or pelvic colon with proximal spread, showing tiny ulcers characterized by spicules of barium penetrating into the intestinal walls and a flattening of haustrations. However, the absence of haustrations in the lower left colon is a common normal finding. The crinkled linear mucosal folds are flattened by the disease and this is most noted on the evacuation films. With increasing involvement, pseudopolyps appear and collar button abscesses are seen along the colonic margins. The entire area being stiffened and contracted, pericolonic fibrosis and narrowing of the calibre of the bowel increases the width of the presacral space as seen on the lateral films. Coalescing ulcers develop into large linear defects with poorly defined margins. If the disease becomes quiescent, the repair by fibrosis and thin hypotrophic mucosa shows the well known "lead pipe." Contiguous involvement of the terminal ileum as a "backwash ileitis" is associated with usually superficial mucosal destruction giving a dilated ileal lumen and a patulous ileocecal valve. Again, repair by fibrosis may give rise to a contracted lumen and a false "string sign." The primary phase of granulomatous colitis will be portrayed as small irregular nodules and scattered superficial ulcers, spicules are not seen, and the skip areas are present. The degree of spasm and irritability will be less than is found in an equivalent degree of chronic ulcerative colitis. The bowel walls are thickened and there is longitudinal shortening, and an occasional stricture will be seen. In advanced disease deep ulcers or pseudodiverticulae are noted. The nodularity is pronounced and termed "cobble stone pavement," and both internal fistulae and sinuses are found. Ileal involvement can be either primary or secondary and is typified by narrowing of the lumen as the "string sign." This is related to spasm and may not be seen on all films. In long standing, diffusely diseased colons it can be difficult to distinguish between the two diseases by radiographic means.

Treatment

Treatment of the two separate disorders is nearly the same. Anemia must be corrected, nutrition improved, avitaminosis corrected and a positive nitrogen balance restored, if possible. Adequate, mental and physical rest is mandatory. A bland, low-residue regimen without rough particulate matter and avoidance of milk is beneficial. Many patients, even with normal amounts of lactase, are intolerant of dairy products and occasionally become asymptomatic upon its withdrawal from their regimens.

Broad-spectrum antibiotics are useful only for secondary infections and are of very limited usefulness in the cases with suppurative sinuses. Salicylazosulfapyridine (Azulfidine), in a dosage of 1 gm or

2 gm four times a day has empirically been of great value. The levels of Vitamins K and C should be maintained throughout its employment. In rectal or pelvic colon disease para-nitrosulfathiazole 10% suspension (Nisulfazole) has been used 2 gm to 4 gm by proctoclysis two or three times daily.

The adrenal steroid hormones, either oral, parenteral or rectally administered, are reserved for cases that do not respond to the simpler measures. The dosage of the steroid hormones is determined on an individual basis. They are used with caution and are distinctly contraindicated in decompensated colons; e.g., "toxic megacolon." Crohn's disease is more resistant to medical therapy.

Surgical treatment is restricted to the cases of either disease that have assumed life-endangering complications, in spite of adequate medical treatment. In general, these are massive bleeding, toxic megacolon, unremitting sepsis, intestinal obstruction, peritonitis either generalized or at times localized, and draining abdominal sinuses. In some instances a dramatic occurrence is not required, the general unremitting decline of a patient, or in the case of a child, failure to thrive is enough indication for intestinal resection.

Clinical Evaluation

During the past three years we have found 60 patients with these diseases at our clinic. Forty-seven of these had chronic ulcerative colitis and 13 had Crohn's disease of the colon. Twenty-four females had chronic ulcerative colitis and 7 had Crohn's disease. The youngest child was 11 years of age and the oldest adult was 85 years. The average age for each disease was 43.

Forty-one patients with chronic ulcerative colitis and 4 with Crohn's disease have been satisfactorily maintained on medical care.

Proctosigmoidoscopic examination was diagnostic of disease in 44 cases of chronic ulcerative colitis and in 2 cases of Crohn's disease. The barium enema was diagnostic for chronic ulcerative colitis in 25 cases and in 13 cases of Crohn's disease. These two complimentary procedures bear out the fact that chronic ulcerative colitis often is only manifested in the rectum and Crohn's disease is very seldom grossly present in the rectum.

A total of 15 patients underwent surgical procedures for disease uncontrolled by medical therapy. Of the 6 patients with chronic ulcerative colitis, 5 had a total colectomy and 1 a right colectomy. (This last case was believed at the time of surgery to represent Crohn's disease, but the histological diagnosis was chronic ulcerative colitis limited to the ascending colon.) Of the group with Crohn's disease, 8 had a right colectomy and 1 a total colectomy for disease that extended to the lower sigmoid colon. In all cases an end-to-end, two-layer, inverting anastomosis was carried out, either ileum to the mid-transverse colon or to the rectum. There were no operative deaths and there has been no patient crippled by surgery. None has intractable diarrhea and all have reported having one to four bowel movements daily. All have gained weight and only 1 patient has been re-hospitalized for recurrent enteritis. (This cleared after two weeks of therapy and has not recurred.) None of these patients is receiving steroid hormones at this time.

It is by no means believed that any of these patients has been cured. However, it is clearly demonstrated that surgical removal of the areas of the colon that are massively involved with either disease is necessary in order that a life-threatening situation can be alleviated and the patient given a chance to attain ascendency over the disorder, if not for a lifetime, at least for a moreorless extended period.

Summary

In summary, both are fairly common diseases that are diagnosed by history, physical examination, proctosigmoidoscopy, radiographic techniques, and histological examination. Chronic ulcerative colitis is mucosal and left-sided, and Crohn's disease is serosal and right-sided. Patients with either disease should be retained in the care of the primary physician until complications necessitate surgical removal of massively involved areas of intestine. Most often in chronic ulcerative colitis this should be a total colectomy, either with or without a proctectomy, depending upon the amount of rectal destruction. For Crohn's disease a right hemicolectomy is most often indicated. Neither disease will be cured by either procedure, for it is believed that these disorders involve the entire colon and there is a marked tendency for continuation and repeated exacerbation. However, removal of the grossly affected area is an integral part of the total care of a fairly large percentage of patients who suffer either with chronic ulcerative colitis or granulomatous colitis (Crohn's disease).

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APLASTIC ANEMIA: CASE REPORT OF AN APPARENT RESPONSE TO THE TRANSPLANTATION OF RIB MARROW

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A 16-YEAR-OLD Caucasian lad was admitted to the Wisconsin General Hospital, Sept. 29, 1939, complaining of weakness. In the late spring of that year, he first noticed aching of the legs after running. This was followed by progressive fatigue. On July 4, after slight nasal trauma, there was a severe epistaxis, controlled with difficulty. Minor cuts about the hands bled for a long time. Because of the severe weakness and increasing pallor, his family physician admitted him to a local hospital, where he received a transfusion on August 6. A second transfusion failed to relieve his marked anemia and he experienced little improvement before his discharge on September 3. Thereafter, on alternate days until admission to this hospital, he was given intramuscular injections of liver extract.

Easy bruisability and numerous small hemorrhages beneath the skin were observed from the early summer and increased progressively until his admission. Before this time weakness had advanced to such a degree that he was compelled to discontinue school, since he was unable to climb the stairs. The inventory by systems added throbbing headaches on slight exertion, moderate tinnitus, and a weight loss of 5 pounds. The personal medical history was irrelevant, and the family history added nothing, save in the negative sense that there was no bleeding tendency in any member of the immediate family. Of special importance was the patient's repeated exposure to a fly spray in the barn for a period of three weeks preceding the onset of his weakness.

Upon physical examination, the patient was well developed and nourished. The skin was deeply pigmented. Numerous petechiae were noted over the trunk and legs. The nasal mucous membranes were covered with bloody crusts and the pharynx was injected. Anterior and posterior cervical adenopathy was noted. The thyroid was small. There was no sternal tenderness. No abnormal signs were established on examination of the lungs. The pulse rate was 90 per minute and regular; blood pressure 115/55 mm Hg. No cardiac enlargement was determined. A systolic murmur was heard at the aortic and the mitral areas. The abdomen was scaphoid. The spleen was felt at the costal margin. The liver was not enlarged. There were no abnormal masses or tenderness. There were no masses upon rectal examination. The remainder of the physical examination, including the neuromuscular system, established no further departures from normal.

The urinalysis was normal. The blood showed a hemoglobin level of 30%, 1,310,000 erythrocytes, 1,675 leukocytes, and 25,000 platelets per cubic millimeter. The differential count disclosed 28% neutrophils, 52% small lymphocytes, 10% young lymphocytes, 7% monocytes and 2% unclassified cells. Three and three-tenths percent reticulocytes and 1 normoblast were noted in the count of 400 leukocytes. Bleeding time exceeded 32 minutes. Coagulation time was 10 minutes and there was no clot retraction at the end of 24 hours.

On the 10th day of hospitalization, the patient developed an acute appendicitis requiring appendectomy, preparatory to which there was a transfusion of 500 ml of blood. The appendix was edematous, densely infiltrated by numerous polymorphonuclear leukocytes, and there was a marked injection of the serosal surface. A few small areas of necrosis were noted over the mucosal surface. Daily transfusions of 500 ml of whole blood were given over a seven-day period after surgery, whereupon his hemoglobin level rose from 25% to 85% and the erythocyte count from 1,300,000 to 5,100,000. Added laboratory studies included a negative serology, blood sugar of 92 mg/100 ml. The basal metabolism was −3% and −6%. The gastric contents contained free hydrochloric acid. The erythrocyte fragility test was normal and the icterus index was 4.

On October 14, a biopsy of the sternal marrow showed it to be largely replaced by fat. A few centers of erythropoietic and leukopoietic activity were noted, but they were very small. Only a few metamyelocytes and granulocytes were seen. The nuclei of the cells were very dark and relatively small. No megakaryocytes were seen. The marrow appeared quite inactive and confirmed the clinical impression of aplastic anemia.

At this time a sample of the fly spray was analyzed and found to contain benzol, benzene, and unsaturated aliphatic hydrocarbons. It was concluded that the benzol and benzene were the probable etiologic factors in the production of the grave pancytopenia.

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The very transient advantage from the multiple transfusions and the necessity for their repetition at least every two weeks to maintain a semblance of adequate blood levels led to the expedient of rib transplants from blood-compatible donors in the father, brother, and paternal uncle. Over a period of three and one-half months, five transplants of segments of ribs, 8–10 cm each, were made into the pectoral muscles of the patient. The cortex of the transplanted rib segments was unroofed along one margin to expose the subjacent marrow before the implantation. At the outset, neither normoblasts nor megaloblasts were seen in the sternal marrow of the patient. At the end of six weeks, however, 82 normoblasts and 1 megaloblast were noted in a count of 400 white cells. Weekly sternal aspirations of the patient's marrow showed a progressive rise to a maximum of 363 normoblasts, 5 megaloblasts and 12 primitive red cells in a count of 400 white cells in the sternal marrow on Feb. 2, 1940. After that time, the levels of these immature red cells remained approximately the same. The percentage of neutrophils in the sternal marrow rose from about 20% at the outset of the transplantations to a level of approximately 50% with an additional 12% young neutrophilic cells. The platelets showed no corresponding rise, only an occasional one being observed. Prior to discharge (Mar. 22, 1940), the peripheral count of platelets did not exceed 8,000 cu/mm in this period, whereas the hemoglobin registered 50%, erythrocytes 2,000,000 and the leukocytes 3,500 to 5,000, with 30% neutrophils, 60% lymphocytes, 6% monocytes, and 2% eosinophils.

■ The patient was followed closely over the next 12½ years. The last admission for the progress study of the hematopoietic system was in November 1951. In the interval, a foot drop of the left leg from peroneal paralysis had developed; but, in general, with occasional epistaxis or other minor bleeding tendency, he had been in excellent health.

The blood counts on the last admission alone arrest our present attention. At this time, his hemoglobin level was 11.75 gm/100 ml, erythrocytes 3,430,000 and leukocytes 3,700, with a differential count of 35% neutrophils, 1% band cell, 53% lymphocytes, 10% monocytes and 1% eosinophil.

On Nov. 27, 1951, 250 ml of whole blood was transfused and on the following day he received 500 ml of whole blood. Thereafter the hemoglobin was read as 12 gm/100 ml. The erythrocytes were 3,750,000, leukocytes 2,738, and the platelets were reported as being present but scanty. Reticulocytes numbered 1.8%, hematocrit reading 37.25%, volume index 1.08, saturation index 0.96, and individual cell volume 99.33 cubic micra. The differential count disclosed 59.4% neutrophils, 0.4% eosinophils, 23.2% small lymphocytes, 0.6% atypical lymphocytes, 8% young lymphocytes, 7.6% monocytes, 0.6% normoblasts, and 0.2% unclassified.

The erythrocytes were well filled with hemoglobin with some variation in size and shape and slight polychromatophilia. The neutrophils showed 2 to 4 nuclei with the majority having 2 lobed nuclei. The lymphocytes were normal in appearance. The sternal marrow was distinctly hypocellular. Lymphocytes predominated. Few of these cells were atypical. Significant was the rarity of myelocytes and plasmocytes. The normoblasts were more frequently encountered than in the peripheral blood. No megakaryocytes and only occasional platelets were discerned in this study of the marrow.

■ In the years intervening since 1951, this patient has engaged in active dairy farming for three years. Thereafter he developed and prospered in an excavation and sewer enterprise. For several seasons (1959 to 1962), he played softball in the summer but tired if there were much running. In the fall of 1963 he was hospitalized for a study of unusual fatigue and dyspnea on exertion. The patient attributed his condition to the seasonal pressure of work. Up to the present time, he is quite active in his field; but he maintains that the operation of the backhoe is the limit of his work capacity, and he reluctantly admits that he is not up to an eight-hour day. He is the father of seven sturdy children.

Through the courtesy of his family physician, Dr. John Buhl, Waukesha, Wisconsin, the clinical notes and laboratory findings of his admission to the Waukesha Memorial Hospital (October 1963) have been afforded. Furthermore, he was later admitted to the University Hospitals, Madison, for surgery of the eye. On Sept. 25, 1967, the following blood count was reported: hematocrit reading 36.5%, hemoglobin level 13.5 gm/100 ml, erythrocytes 3,400,000, platelets decreased, leukocytes 3,400; the differential count: neutrophils 57%, eosinophils 2%, lymphocytes 40%, and monocytes 1%.

Immediately after the initial clinical experience with the rib transplants, a study of the homotransplantation of ribs in standard anemia dogs was instituted. The primary interest was in the fate of the marrow in the transplanted rib segments in these animals. Then their effect upon the peripheral blood picture of the standard anemia dogs was studied. The protocols of these experiments are no longer available; but there was early replacement of much of the transplanted marrow by lymphocytes and fibroblasts. However, within the period of days, there had appeared some evidence of enhanced erythropoiesis in the increase of immature red cells in the peripheral blood.

Obviously, in the instance recorded, all cellular elements of the marrow; i.e., erythromyeloid and megakaryocytic, had been depressed by some toxic agent, presumably the fly spray with its benzene–benzol content. Without sophisticated methods of establishing compatibility, the natural recourse to rib transplants as a source of marrow was undertaken.

Apparently the lamed marrow of the patient was supported and perhaps stimulated to a degree, but after 28 years there was still appreciable depression of the marrow. In the intervening 29½ years, the patient has led an active life and at 45 years of age is a sturdy, healthy-appearing individual. Since that time, rib transplantations have been made in two other patients with different bases for anemic states without success.

In relating this isolated experience, the apparent supportive role of the rib transplants is cited. Obviously, the actual mass of marrow contained in the ribs could not have been the determining factor. If stimulation occurred, the effect must have been through some humoral agent. From another aspect, the course was interesting in the apparent disparity between the responses of the erythromyeloid and the megakaryocytic elements.

Naturally, the issue of the monophyletic versus the polyphyletic theories could be raised. If the observation of a differential response both to the toxic etiology and to the assumed stimulus of the transplants be sustained, then the theory of a pluripotential stem cell for all three marrow elements might be applied. Particularly is this position tenable, if it is assumed that a committed precursor cell acts as a step from the primitive to the ultimate differentiated element for delivery to the circulation. Certainly, the initial lag in the appearance of the platelets was inescapable, and the sequential studies of the marrow reinforced this conclusion.

Obviously, this isolated experience in a day when the tools were limited, in no sense detracts from the brilliancy of the recent work in histocompatibility that will advance the knowledge and eventually the treatment of such hematologic situations with definition and direction. □

PULMONARY MELIOIDOSIS: A DIAGNOSTIC DILEMMA AND INCREASING THREAT

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Melioidosis is an infectious disease in man and animal caused by the Gram-negative bacillus *Pseudomonas pseudomallei.* The organism is found only in southeast Asia and only presents a problem in this country as a result of our involvement in that area. It is estimated that 8% of military personnel have evidence of contact with this organism. In its pulmonary forms melioidosis mimics tuberculosis since it may occur as a cystic cavitary disease, pulmonary infiltrates, pleural effusion, empyema, or a tracheobronchitis. In the more chronic form it is most likely to be confused with tuberculosis or some of the other granulomatous diseases.

There is, however, an acute septicemic form of the disease which apparently occurs in patients suffering severe trauma. The septicemic form following trauma may occur as much as 10 years following contact with the disease. A patient is described who having recovered from a minor burn in southeast Asia, some months later suffered a 70% burn in the United States. Although there had been no evidence of pulmonary melioidosis on his first admission to the Surgical Research Unit, he had the symptoms of acute septicemic melioidosis. He died and melioidosis was found in the lungs, liver, spleen, and kidneys with no evidence of a chronic source of infection. This type of presentation is important. Should any patient who has been to Vietnam appear in the trauma or accident rooms with severe trauma and whose course is otherwise uncomplicated suddenly develops fevers up to 104 and 105 F have respiratory complications, dyspnea, tachypnea, and a decreasing arterial Po_2, then the thought or suspicion of melioidosis with institution of tetracycline therapy may be life-saving.

The chronic form of disease is most often found as a result of the patient being investigated for pulmonary cavitation or infiltrates. Culture of the organism is straight-forward as long as one is familiar with the unusual umbonate center to the organism with its radial wrinkling. The development of this characteristic radial wrinkling is hastened by placing the culture plate at room temperature. The organism in the first 24 hours appears as any other Gram-negative coliform. The treatment of the disease, although controversial, has been best managed with massive tetracycline, 2 gm intravenously for a minimum of one week with continuants of oral tetracycline for one to two months.

The role of surgery in removing the cystic cavity remnants of melioidosis is as yet undecided; however, since these areas may be the source of a residual of infection, it may well be that they should be removed under antibiotic coverage. We feel it is safe to say that melioidosis should be added to the differential diagnosis in persons presenting with pulmonary infiltrates or cavitation who have been to southeast Asia. The septicemic form is highly lethal within 24 to 48 hours and early recognition of the tachypnea, decreasing oxygen tensions, air, hunger, and high fever may be the only promontory signs or symptoms. Only awareness of this disease and the lethal potentialities of this unusual organism will permit one to recognize the early clinical manifestations and to effectively treat such cases. □

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COMPARATIVE STUDY OF GLUTAMIC OXALACETIC TRANSAMINASE AND CREATINE PHOSPHOKINASE VALUES IN THE DIFFERENTIAL DIAGNOSIS OF MYOCARDIAL INFARCTION

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THE USEFULNESS of creatine phosphokinase (CPK) determinations in the diagnosis of myocardial infarction has been evaluated. The results reported represent those obtained from 264 serum specimens collected for enzyme assay only upon request, so that the usefulness of patterns created in this manner, as the physician sees them, could be evaluated. It appears that although not ideally specific, the determination of CPK activity provides a better diagnostic tool than a number of enzyme tests which have been relied upon in the past.

CREATINE PHOSPHOKINASE (CPK), an enzyme which catalyzes the phosphorylation of creatine, is found in high concentrations in skeletal muscle, cardiac muscle, and brain tissue. Serum levels of the enzyme have been reported by some investigators[1-3] to be elevated in cases of myocardial infarction, Duchenne-type muscular dystrophy, and polymyositis. The measurement of CPK activity may also be of limited value in confirming cerebral vascular accidents.[4] It has also been reported that CPK values are increased in cases of hypothyroidism and that an inverse correlation exists between CPK and protein-bound iodine (PBI).[5] CPK values are not elevated in cases of liver disease, renal infarction, hemolytic anemia, pulmonary embolism, solid tumors, or leukemia.

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This report is sponsored by Herman J. Dick, M.D., Director Laboratory, Sheboygan Memorial Hospital.

Each of the commonly used enzyme determinations which are of value in confirming myocardial damage has certain advantages and disadvantages. For example, lactic dehydrogenase values remain elevated for a comparatively long duration following myocardial infarction although levels may also be elevated by disease processes other than those involving the heart. Glutamic oxalacetic transaminase (SGOT) values which are increased in cases of myocardial infarction are also considerably increased in conditions associated with liver necrosis and can therefore contribute to a somewhat confusing picture.

It is essential that serial SGOT tests be performed before myocardial infarction can be confirmed. In some instances when myocardial injury has actually occurred, test values may never exceed the "normal range" but instead may fall within the range considered "borderline." Therefore, the advantage of a test for which a more definite normal value can be established is obvious.

This study was conducted in an effort to answer these questions:

1. How organ-specific is CPK?
2. What cardiac/cardiovascular abnormalities other than myocardial infarction influence CPK results?
3. Are CPK values of greater interpretive significance to the clinician earlier than SGOT values?

In considering the last question it must be remembered that patients may not be examined at the onset of pain and may not reach the hospital until both SGOT and CPK values have become elevated. In comparatively obscure cases of chest pain, enzyme studies may not be requested for some time following the patient's hospital admission and in these instances it obviously becomes difficult to ascertain whether CPK values become elevated earlier than SGOT values.

The study population consisted of 197 inpatients who diagnostically represented a cross section of conditions. A CPK test was performed on 264 specimens which were obtained for SGOT assay, since it was assumed that the latter test had been requested on the basis of its value in confirming or ruling out either cardiac or hepatic disorders. It was hoped that this criterion would provide a rather select population and a means by which each condition's effects on the CPK test could be evaluated.

Assay Methods

Specimens were assayed for SGOT using the colorimetric method of Babson et al. Results were calculated from a standard curve which had been prepared using Versatol E* and Versatol E-N* as recommended in the procedure literature.

Creatine phosphokinase assays were also performed colorimetrically according to a procedure outlined by Sigma Chemical Company** from whom all reagents were obtained. Test serum was incubated at 37 C with adenosine triphosphate, reduced glutathione, and a creatine solution pH 9.0. The phosphocreatine produced was then hydrolysed to produce creatine and inorganic phosphorus. The phosphorus was then measured by the method of Fiske and SubbaRow.[9] The values of phosphorus in micrograms was determined using a standard phosphorus curve and the value of the test subtracted from the phosphorus blank. The difference in phosphorus values was then converted to CPK units as recommended by the reagent manufacturer.

* Warner–Chilcott Laboratories, Morris Plains, N.J.

** Sigma Chemical Company, St. Louis, Mo.

TABLE 1—*Criteria for Classification by groups*

Group	Criteria for classification
II-A	Myocardial infarction reported either in ECG report or discharge summary.
II-B	Ischemia or "ischemic episode" reported either in ECG report or in discharge summary. No complicating disease reported.
II-C	Ischemia or "ischemic episode" reported either in ECG report or in discharge summary. Complicating disease reported.
II-D	Miscellaneous cardiac/cardiovascular abnormalities reported either in ECG report or in discharge summary. No complicating disease reported.
II-E	Miscellaneous cardiac/cardiovascular abnormalities reported either in ECG report or in discharge summary in addition to complicating disease.
II-F	"Nonspecific injury" reported.

Reporting

In this method, one CPK (Sigma) unit is equal to the amount of creatine phosphokinase which will phosphorylate one millimicromole of creatine per minute at 25 C under conditions based upon an ultraviolet method described by Sigma Chemical Company. The normal CPK range using this method is 0–12 units per milliliter. Values between 12 and 20 units are described as "borderline."

Twenty-five SGOT units are defined as the amount of enzyme that will form 25 micromoles of oxaloacetic acid per minute per liter of serum at 37 C in a pH of 7.4. Values up to 36 units are considered normal.

Patient Classification

All patients were categorized as being either cardiac or noncardiac. General classification I consists of those patients who met one or more of the following criteria: (1) no electrocardiogram had been performed, (2) electrocardiographic (ECG) tracings were reported as normal, and (3) no cardiac/cardiovascular abnormalities were described in the patient's diagnosis. General Classification II consists of patients who were considered as being cardiac or cardiovascular cases. Classification was based on either of the following criteria: (1) ECG tracings disclosed abnormalities, or (2) cardiac and/or cardiovascular abnormalities were described in the discharge diagnosis despite normal ECG findings at the time of testing.

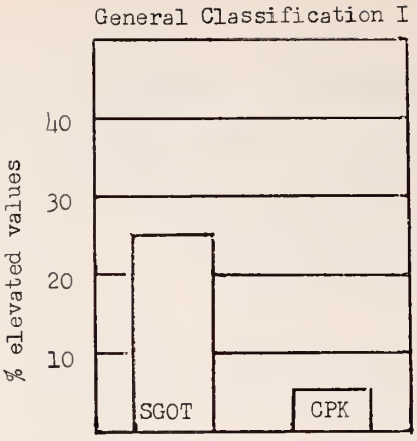

Fig. 1—Distribution of enzyme values in cases classified as "noncardiac."

Patients included in general classification II were subgrouped in six categories as outlined in Table 1.

Results

General Classification I (noncardiac patients)

This group includes 97 patients and 102 SGOT and CPK determinations. None of these patients presented history of cardiac or cardiovascular abnormalities nor were ECG tracings, when performed, abnormal.

As illustrated in Figure 1, SGOT values were elevated in approximately four times as many instances as were CPK values.

Eight cases were reported as hepatic or biliary disease. The test results obtained in these cases are illustrated in Figure 2 (A). The postmortem diagnosis of one patient included generalized jaundice in addition to multiple pulmonary infarcts and pancreatitis.

The results of those cases diagnosed as carcinoma with or without metastasis are illustrated in the second half of Figure 2 (B).

Six CPK values in general classification I were above 12 units without apparent cause. In two of these cases SGOT values were also elevated. Electrocardiograms were performed in five of the six cases and in each instance no abnormalities were reported. Only one CPK value exceeded 20 units. The average value of the six was 17.6 units. The range of SGOT values was 17 to 42 units with an average value of 26.6 units.

General Classification II (cardiac and cardiovascular patients)

General classification II consists of a group of 110 patients all of whom presented electrocardiographic or clinical evidence of cardiac abnormalities, or both. In 40 cases myocardial infarction reportedly occurred. Test results of this group are considered separately in this report.

The percentage of elevated enzyme values in this group is illustrated in Figure 3.

The discharge diagnosis in 42 cases included additional disease which could account for either SGOT or CPK elevations. These particular cases have been grouped on the basis of accompanying cardiac abnormalities reported and are considered separately in this report.

Group II-A

Figure 4 illustrates the results of 73 SGOT assays compared with the results of CPK assays run in parallel on sera from patients who, accord-

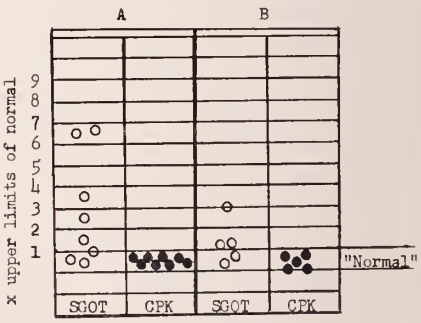

Fig. 2—Distribution of enzyme values obtained in cases of hepatic disease (A) and carcinoma (B).

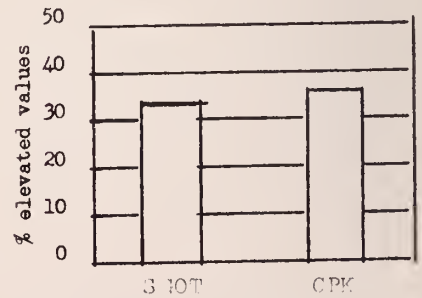

Fig. 3—Enzyme values obtained in 110 cases classified as "cardiac" and/or "cardiovascular."

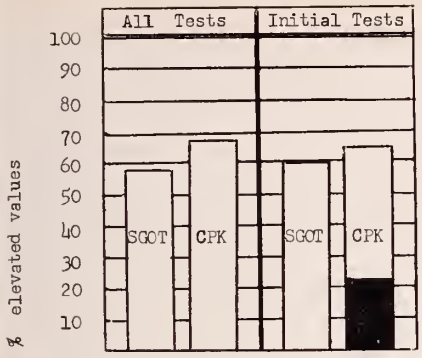

Fig. 4—Enzyme results obtained in cases of reported myocardial injury. Distribution of initial test values illustrated in second half of Figure 4. Shaded area of CPK bar illustrates the percentage of values between 12 and 20 units.

ing to either electrocardiographic findings or discharge summaries, had experienced myocardial injury. The patients in this group represent cases involving all degrees of myocardial damage.

Electrocardiographic evidence of myocardial infarction was presented in 31 cases. In six instances infarction was not demonstrated by electrocardiogram; however, it was reported in the patients' discharge summaries, indicating that enzyme values were taken into consideration.

Seven patients in this group maintained SGOT and CPK levels which were within the normal range despite reported myocardial infarction in either electrocardiographic report or discharge summary. Two of these seven ECG reports included abnormal findings other than myocardial infarction, one report described a small degree of myocardial injury, one report described a "healing myocardial infarction" and one other a "relatively small myocardial infarction."

Initial enzyme test results in group II-A were compared with the results of electrocardiograms taken at the time of testing. These results, illustrated in the second half of Figure 4 probably represent the findings of greatest interpretive value since this is the point in testing nearest the patient's hospital admission when in many cases symptoms are most acute.

The use of a "borderline" classification for CPK test results may be evaluated through the interpretation of the findings compared in the second half of Figure 4. It might be noted that 67.5% of those CPK values obtained during initial testing were greater than 12 units while more than one-third of the elevated CPK values fell within a range between 12 and 20 units (shaded area).

The average initial SGOT value in this group was 78.9 units, or 2.2 times normal. The average CPK value was 39.8 units, or 3.3 times normal.

Group II-B

In group II-B the results of tests performed on sera from patients whose electrocardiographic reports or discharge summaries, or both, included ischemia are compared. None of the discharge summaries for patients in this group included reports of additional disease.

Six and two-tenths percent of all SGOT values and 25.0% of all CPK values in this group were above the upper limits of normal. In one case three successive CPK values were elevated but myocardial damage was not demonstrated on ECG tracings.

The average SGOT value in this group was 17.1 units and the average CPK value was 11.1 units.

Group II-C

Seven patients were included in group II-C. Unlike patients in group II-B, these cases which included reported ischemia were complicated by additional disease.

In three cases SGOT values ranged from 55 to 328 units. Only one CPK value was above 12 units. One case was diagnosed as carcinoma of the pancreas with metastasis to the liver, one as biliary obstruction, and one as diabetes.

Group II-D

Those cases which could not be classified in one of the previous groups were included in group II-D. Electrocardiograms demonstrated abnormalities other than myocardial infarction or ischemia, and in numerous cases multiple abnormalities were noted. None of the cases was complicated by additional disease.

SGOT values were elevated in four cases and three CPK values were above normal. CPK values were not elevated in the same instances in which SGOT values were abnormal.

There was no obvious correlation between the seven abnormal enzyme values and the respective discharge summaries. Elevated SGOT values ranged from 37 to 56 units, and CPK values fell within a range of 18 to 33 units.

Group II-E

Thirty-one patients presented abnormal electrocardiographic tracings or discharge summaries, or both, which described miscellaneous cardiac/cardiovascular disease in addition to complicating disease.

Five SGOT and CPK values, respectively were abnormal. In only one instance were both enzyme values elevated and in this case the electrocardiogram finding was that of an old myocardial infarction but cerebral infarction was reported in the discharge summary. The following diagnoses were reported in those cases in which SGOT values were elevated: (1) old myocardial infarction and cerebral infarction, (2) adenocarcinoma of the transverse colon, (3) fatty metamorphosis of the liver, (4) pancreatitis, and (5) pulmonary embolism.

Group II-F

Only one patient was categorized in this group. Nonspecific injury was reported in this patient's ECG report and myocardial insufficiency later in his discharge summary. Three SGOT and CPK determinations were performed. Except for the initial CPK value, which was slightly elevated, all test results, including subsequent CPK determinations, fell within the normal range.

Summary

The results of 264 SGOT and CPK assays in 197 cases have been evaluated with attention directed toward test results as correlated with clinical and electrocardiographic findings rather than attempting to use a purely random popula-

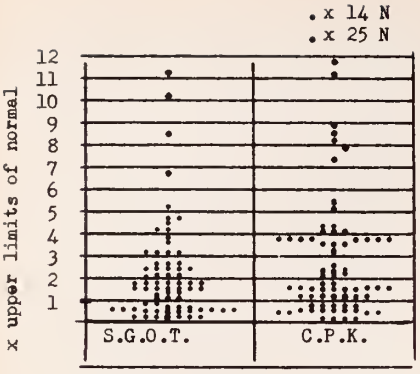

Fig. 5—Distribution of SGOT and CPK values in cases of myocardial infarction.

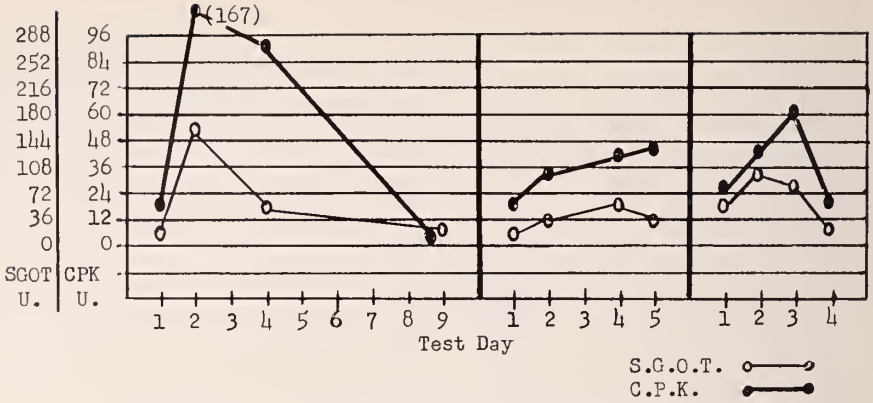

Fig. 6—Examples of serial enzyme assays in cases of myocardial infarction. Rate of ascent and decline and degree of elevation illustrated.

tion and then compare enzyme test results with diagnosis.

Three questions have been posed, and to some extent the results presented have provided answers which might be considered conclusive.

The organ specificity of creatine phosphokinase (CPK) compared with that of glutamic oxalacetic transaminase (SGOT) has been evaluated and it appears that the former, although not ideally specific, provides results which may be considered with greater confidence when seeking confirmation of myocardial injury in cases that are complicated by other disease. Those factors which influence transaminase (GOT) results have no demonstrable effect on CPK values.

When the results of all assays, excluding those performed in cases of myocardial infarction were compared, disregarding discharge summaries, it was found that 38% of all SGOT values were elevated and only 19% of all CPK values were above normal.

When the percentage of elevated enzyme values in general classification I (noncardiac) was computed, it was found that there were approximately four times as many potentially misleading SGOT elevations as there were CPK elevations.

In those cardiac/cardiovascular cases other than myocardial infarction which were studied, 19% of the initial SGOT values were elevated as compared with 14% CPK elevations. In a number of cases SGOT elevations were explainable when complicating disease was considered. With the exception of one abnormal CPK which was found in a case of cerebral infarction, there was no obvious correlation between elevated CPK values, the patients' discharge summaries, and causes of CKP elevations previously reported by others. It was not possible to find a common factor in electrocardiographic reports which might suggest that cardiac abnormalities other than myocardial infarction significantly affect CPK values.

In cases of reported ischemia 17.6% of both initial SGOT and CPK assays were abnormal. However, in two instances complicating disease could have accounted for the SGOT elevations. This might suggest either greater CPK sensitivity than desirable or possibly the inability to detect slight degrees of myocardial damage on electrocardiographic tracings.

The usefulness of CPK determinations in confirming myocardial infarction earlier than is possible with SGOT assays appears to be slightly greater. Sixty percent of the initial SGOT determinations in cases of myocardial infarction studied were elevated. Sixty-five percent of the initial CPK results in this same group were above normal.

The degree of SGOT elevation was compared with that of CPK, and the distribution of all test values obtained in cases involving myocardial infarction is illustrated in Figure 5.

Although serial enzyme determinations were requested in a relatively small group of myocardial infarction cases, it appears that the rate of elevation and duration of elevation of SGOT and CPK nearly parallel each other. In a few instances CPK values became elevated earlier than did SGOT values.

As illustrated in Figure 6 the degree of CPK elevation, however, was considerably higher than that of SGOT. This fact may provide an asset in the early detection of myocardial injury.

When reviewing those cases in which serial determinations were performed, it was found that CPK activity reached its peak on the first or second day of testing and that values usually returned to normal between the second and ninth day. The relationship between duration of CPK elevation and prognosis was not studied.

Recent reports suggest that the identification of CPK isoenzymes may provide greater organ specificity than is presently recognized, thus adding to the clinical usefulness of the test.

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ENZYME CHANGES IN MYOCARDIAL INFARCTION

By THEODORE ROWAN, M.D., Beaver Dam, Wisconsin

THERE HAS BEEN a great increase in technical knowledge and clinical use of enzymes in the last decade, providing information about many disease processes that are associated with tissue damage or destruction. Ideally, an enzyme should be specific for a particular tissue, organ, or disease process. A few enzymes approximate this as ceruloplasmin in Wilson's disease, and alkaline phosphatase partition in liver or bone disease. For the most part we are dependent upon a selection of enzymes and estimating from them associated tissue damage. The speed with which enzymes are liberated and the length of time that their elevations can be detected in the blood can often help in diagnosing a disease or its time of onset. Of recent interest and importance has been the expansion of diagnostically usable enzyme determinations in patients with heart disease or chest pain of varying etiology, principally in myocardial infarction.

A study was undertaken to determine the most practicable and informative tests that could be used in individuals with heart disease and the tests considered to be of most use, and utilized in this study, were serum glutamic oxaloacetic transaminase or aspartate aminotransferase (referred to as SGOT), creatine phosphokinase (CPK), serum alpha hydroxybutyrate dehydrogenase (SHBD), and lactic dehydrogenase and its isoenzymes (LDH and isozymes).

Materials

Cardiac enzyme panels were run, in whole or in part, on 41 patients, representing myocardial infarction (9), arteriosclerotic heart disease (15), subacute bacterial endocarditis (1), pericarditis (4), pulmonary embolus (2 plus 2 complicating other major conditions), miscellaneous entities (6), and controls.

Results

The study confirmed the diagnostic utility of these enzymes in myocardial infarction and the well established pattern of time relationship of enzyme changes to the infarct.

The panel of tests was most helpful in complicated cases such as sudden hypotension with or without chest pain, complications of cerebrovascular accidents and helping to delineate pulmonary embolism. One patient went into severe congestive heart failure a week after having a myocardial infarction and diagnosed as having developed a ruptured interventricular septum. The LDH isozyme electrophoretic strip showed an almost entire representation by LDH_5* associated with anoxic necrosis of the liver from the acute failure. Another case that was diagnosed as myocardial infarction on the basis of the ECG changes associated with severe chest pain, was revised to pericarditis after normal enzyme values were obtained.

Iatrogenic Aberrations

There have been occasional reports of abnormal enzyme results secondary to medications, and a recent paper has referred to the phenomenon of iatrogenic pseudomyocardial infarction.[1] Opiate-induced hypertransaminasemia, like lipase, amylase and occasionally LDH, has been noted for 2 to 24 hours in those in whom there is biliary tract disease or in the absence of a gallbladder, and these elevations may be very high. The increased biliary tract pressure may produce all of the symptoms and findings of myocardial infarction. Salicylates have been reported to elevate the SGOT.

In order to increase the sensitivity of CPK reactions, some hospital laboratories have adopted a sensitized system. Iatrogenic elevations of CPK may occur with aqueous penicillin given intramuscularly four to five times the upper limits of normal, and morphine, analgesics and diuretics may cause similar reactions. This may last for up to 48 hours.

Any hemolytic process will be associated with elevations of LDH_1 and LDH_2 or SHBD. This may

Abstract of a paper on "Diagnostic Enzymology in Myocardial Infarction and Acute Chest Pain," presented at the Annual Meeting of the Wisconsin Society of Pathologists, Oct. 16, 1968.

Doctor Rowan is associated with Consultant Physicians in Pathology.

* When LDH isozymes were separated by heat fractionation, the cardiac heat resistant fraction was known as LDH_5 and the heat labile liver fraction as LDH_1. Now that electrophoretic separation has become widely adopted the more logical European nomenclature is used—the fast traveling "cardiac" fraction is LDH_1 (really LDH_1 and LDH_2) and the slow moving liver fraction is LDH_5, analogous to serum protein electrophoresis nomenclature.

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TABLE 1—*Suggested "Cardiac" Enzyme Panel*

	Day 1	Day 2	Day 3	Day 7–10
CPK	+	+	+	
SGOT	+	+	+	
LDH Total	+	+		+
LDH Isozymes		+		+

be seen in the post-cardiotomy patient in whom a prosthesis has been inserted, sometimes after a blood transfusion, and similar patterns are also seen associated with pernicious anemia and renal necrosis.

Direct-current countershock therapy in the treatment of cardiac arrhythmias may produce elevated CPK values with normal SGOT values. This is considered, therefore, to be related to the shock and associated skeletal muscle damage, and not with a possible myocardial infarction.[2, 3]

Although less important, it should be remembered that enzyme levels may be depressed, as SGOT by phenylbutazone and isoniazid, and LDH by mercuric chloride, EDTA, and oxalate.[4]

Two patients in this series had an enzyme elevation following parenteral meperidine hydrochloride when no disease process was established and while all CPK, SGOT, SHBD, LDH, and isozyme determinations remained normal. In one the SGOT increased three and one-half times above the upper limit of normal and stayed elevated for two days. In the second case, the CPK rose to three times the normal value and was elevated for two days.

Discussion

SGOT and more recently CPK determinations have become standard enzyme tests in confirming a diagnosis of myocardial infarction and in estimating damaged tissue and prognosis. Any additional information that can be obtained in difficult diagnostic presentations, complications of existing disease processes, postoperative status, or for better evaluation of prognosis, is desirable.

CPK is very sensitive and determinations should be performed because this enzyme is the first to show demonstrable changes in the blood, and it is specific for muscle (and brain) damage. It also may be elevated in trauma of any sort and vigorous physical exercise.

Transaminase determinations should be performed because the enzyme is widely distributed, and it is a sensitive indicator of any tissue damage; therefore, it may show elevations when there is tissue damage that is not of muscular origin. Both the CPK and the SGOT determinations should be performed to exclude the possibility of iatrogenic alteration in one, or possibly laboratory error, especially as the majority of patients with acute chest pain will have received an intramuscular injection of an opiate or similar drug before blood is drawn for enzyme determinations.

LDH totals by themselves have one advantage only over CPK and SGOT determinations, and that is if tissue damage has occurred three days or more earlier, in which case the other two enzymes may be normal while the LDH will be elevated. SHBD comes in the same category. However, the addition of LDH isozyme determinations or Inhibition LDH* studies considerably increases the specificity and utility of the LDH determination.

Conclusions

A modified cardiac enzyme panel is recommended (Table 1) for investigation of chest pain. This is a standard group of tests in our area and an additional approximately 80 panels have confirmed our original impressions.

This group of tests is recommended for their combined sensitivity, specificity, exposure of possible iatrogenic alterations, and prognostic implications. A straight-forward example of myocardial infarction may be simply confirmed by an SGOT or CPK determination on three successive days, but even in these cases congestive heart failure might supervene and might go undetected for a period of time. LDH isozymes may indicate this and influence the physician's therapy. Isozymes can be usefully run for 7 to 10 days or longer while there is evidence of active heart disease or heart failure.

The LDH Inhibition ratio is a good alternative to LDH isozymes by electrophoresis, if the latter is not available. The SHBD/LDH ratio is considered of little value. The SHBD as a single test is helpful, but if more than one test is employed, as suggested, it may be eliminated.

It should be remembered that hemolysis of any origin will significantly affect LDH and SHBD results, but will not change a CPK value.

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* Profile LDH (Warner–Chilcott), a biochemical method for estimating isoenzymes with a normal ratio of 0.8 to 1.2. In myocardial infarction, the ratio is depressed below 0.8, usually below 0.6, and in liver disease the ratio is above 1.2, usually above 1.5.

ACKNOWLEDGMENT: I wish to thank Dr. P. R. Glunz for assistance in organizing this study and associated controls, and Drs. J. L. Algiers and M. J. Mally for their cooperation with patients under their care.

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THERAPEUTIC DILEMMAS

COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They are published in a selective manner monthly, except January.

Editor: HARRY BECKMAN, MD, Houghton Fellow in Clinical Research and Consulting Physician, Columbia Hospital

No. 22 of a Series

DIVERTICULITIS

Moderator: GLENN H. FRANKE, MD

Participants: DELBERT HAHN, MD
ROBERT W. BYRNE, MD
PHILIP B. O'NEILL, MD
THOMAS WALL, MD

Dr. Glenn H. Franke: Colonic diverticula are unusual before the age of 40, but thereafter their occurrence is in rather direct proportion to the advancing years. Two-thirds of the populace in the 70s and beyond are said to be blessed with these little outpouchings of the colonic mucosa, and probably as high as 25% of these individuals will develop the inflammatory state known as "diverticulitis." It is with the therapeutic dilemmas posed by this diverticulitis that we are to deal this morning. Doctor Hahn will present a brief protocol of the case.

Dr. Delbert Hahn (Intern): A 55-year-old white woman, had a 6- to 8-year history of diverticulosis with occasional flare-ups of diverticulitis and accompanying disturbances in bowel habits. In August of this present year she developed a partial bowel obstruction with a cicatrix of the sigmoid colon; a transverse colostomy was performed at that time. There were no postoperative problems and she learned to irrigate the colostomy very effectively once daily. In the middle of December she was readmitted for the second stage of the three-stage surgical procedure, the removal of the cicatricial mass and performance of the anastomosis. There were no particular postoperative problems and she was discharged yesterday. She will return in a few weeks for the final or third-stage procedure, the closing of the colostomy.

The patient's medical history was noncontributory, and so also was the family history. Physical examination at the time of admission for this second-stage procedure revealed nothing of significance except the colostomy and a mass in the left cul-de-sac. Hemoglobin was 13.9 gm/100 ml; hematocrit reading 41%; and a white blood cell count of 9,600/cu mm with a normal differential count.

Dr. Franke: Doctor Byrne will show us the x-ray films from this case and briefly discuss the radiological aspects of this disease.

Dr. Robert W. Byrne (Department of Radiology): Colonic diverticula are pockets of mucosa which bulge through the muscularis, usually at sites of perforations of blood vessels. We see them in all sizes and shapes. Here in this film from another case (Fig 1) you see them filled with barium in an assortment of sizes, some of them showing ring shadows (as at A) indicating that they contain fecal material. They are found predominantly in the left colon, particularly in the sigmoid area, although they may be scattered elsewhere in the colon. Yesterday I had two cases of diverticula formation limited to the right colon, but this is unusual. Sometimes when the number of diverticula is large and there is evidence of irritability and spasm, we get the sort of picture that we describe as a saw-tooth contraction, as at B in Figure 2. A single diverticulum, becoming inflamed can cause trouble, but in the vast majority of instances we are dealing with a number of them, and often a tender mass can be felt. This may be deceiving, however, when we are attempting to differentiate between diverticulitis and carcinoma, as is often necessary, because carcinoma itself can present as a tender mass when there is

Figure 1

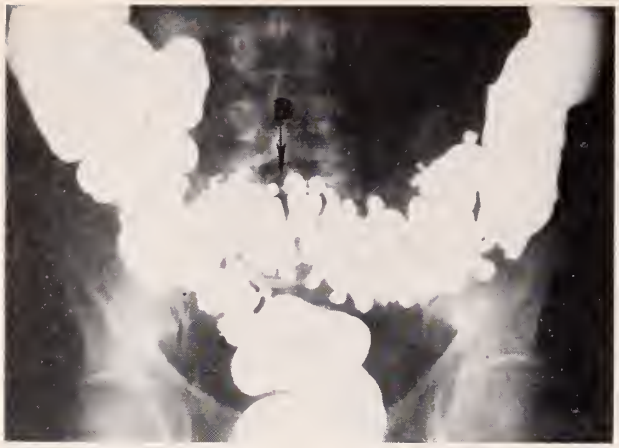

Figure 2

Figure 3

Figure 4

Figure 5

some inflammation in the area. The diagnosis of diverticulitis is often fraught with trouble for the radiologist, who may find it necessary to make repeated examinations in order to observe the gradual regression of an intraluminal lesion. Sometimes it is impossible to rule out carcinoma and resort must be had to surgery for diagnosis.

Coming now to the present case, I show the film (Fig 3) made in August in which the retrograde obstruction in the lower sigmoid is obvious. It was impossible to cause barium to flow proximal to this area. However, there was no suggestion of any degree of overhanging margin such as we look for in carcinoma; and by the time we saw the patient again in December some barium could be made to go beyond the obstruction (Fig 4), and above this we could see a nice mucosal pattern. The spot films we obtained at this time were a little disturbing because there was suggestion in them of lipping and an overhanging margin, as at C in Figure 5; but this did not occur at the proximal end, and my opinion remained that this was diverticulitis and not cancer.

Dr. Franke: Dr. O'Neill, would you like to discuss diverticulitis from the gastroenterologist's standpoint?

Dr. Philip B. O'Neill: The etiology of diverticulosis is still in a conjectural stage. Increased intraluminal pressure has been postulated, particularly because of the relative fixation of the sigmoid loop in which most of the diverticula are found. Herniation of mucosa, connective tissue and blood vessels in an investing vascular network, is a characteristic finding but not an explanation. Impaction of fecal material in diverticula is alleged to account for the development of inflammation and the lesion we know as diverticulitis, but no inlet or outlet spasm of the diverticula has actually been demonstrated in substantiation of this claim. Increased mucosal friability, necrosis, and bacterial inflammation also are held responsible by some observers, while others would invoke the concept of myochosis, a process in which there is hypertrophy of heaped up muscle

as seen in protracted irritable colon. All of this is only speculative.

Diverticulitis is characterized by its lengthy course and intermittency in contradistinction to carcinoma, in which there is more rapid progression and greater severity in symptomatology. Abdominal pain may be dull to moderate or severe and is usually localized in the left lower quadrant. Tenderness and a palpable mass are sometimes present. Abdominal distention is common, particularly if there is some obstruction. Leukocytosis, fever, and an elevated sedimentation rate are not unusual. Alteration in bowel habit is much as we see it in irritable colon, diarrhea or constipation, or both. In one series of patients reported in recent years, there was considerable low back pain, which is not surprising since colonic pain of other origins is sometimes transmitted into that area.

It is estimated that about one-third of the patients with diverticulitis have blood in the stools. The bleeding may be small to massive but it is commonly intermittent; a massive colonic hemorrhage is considered by some observers to be indicative more often of diverticulitis than of carcinoma. The presence of pneumaturia and fecaluria are ominous signs of course, indicative of fistulous tracts from the sigmoid into the bladder.

Sigmoidoscopy must be done with extreme care in these cases because of the spasm and is helpful only in a negative way to rule out low colon or rectal cancer; it is extremely uncommon to see the ostia of diverticula. A barium enema has to be given with great caution because of the possibility of rupturing an inflammed diverticulum. A scout film of the abdomen may be of help in the patient with obstruction.

■ In differential diagnosis, we need to consider almost exclusively lesions of the left colon since that is where most diverticula are located: Crohn's disease, carcinoma of course, endometriosis with formation of an endometrioma, volvulus, intussusception, irritable colon syndrome, ulcerative colitis.

Medical therapy can be effective in reducing morbidity. Antibiotics; bed rest with local heat and retention oil enemas for local soothing effect; use of meperidine (Demerol) rather than morphine, which has been shown to increase the spasm; stool softeners; and a liquid diet progressing to a low-calorie and a low-residue one because these people are often obese—this is the approach that is employed in an attempt to forestall surgery.

Dr. Franke: Doctor Wall will now discuss the surgical problems encountered in this entity.

Dr. Thomas Wall: The present patient will serve particularly well to exemplify the surgical dilemma in diverticulitis. She was very stoical and was able to help us very little in the matter of a historical account of her difficulties; she had minimal pain in the left lower quadrant; but she was afebrile, had a normal white blood cell count, was eating well, and was really not very ill. But as you have seen from Doctor Byrne's x-ray films, she had a severe retrograde obstruction—and we were worried, being fearful of carcinoma.

■ So we prepared her for exploration with the mechanical and antibiotic method that I still favor, which was possible because there was no obstruction to the distal progression of the stool—and lo and behold we found, on going in, that despite her paucity of clinical symptomatology there was a huge mass filling the whole pelvis, with the entire left side adherent to the uterus. We took the precaution of having a urologist, Doctor Gute, pass a catheter up the left ureter as a safe-guarding measure when undertaking to remove a mass of this sort; but our final decision was not to do a primary resection because we were able to exteriorize or see two-thirds of the circumference of the bowel wall and felt confident that we were not dealing with carcinoma. It therefore appeared advisable to wait for the acute inflammatory situation to quiet down before resecting. (Had it been carcinoma, we would have resected at once, of course.) So, as definitive surgery at that first operation, we only did a colostomy as the first stage of a three-stage procedure.

■ At the time of the second operation, the recent one, we found that approximately 12 inches of the colon had been involved in diverticulitis at multiple sites. One small diverticulum had ruptured near the apex of the vagina and there was a granuloma there, the result of a previous abscess between the septum of the vagina and the lower part of the rectum. Of course we were now very pleased that we had elected a three-stage procedure in this instance, in view of all this pathology. The anastomosis that was done after the resection was a difficult one low down in the pelvis, but the patient's progress has been excellent. We shall have her back again shortly for the final, or third stage—the closure of the colostomy to return her to a normal type of evacuation.

■ In former times we resorted to surgery in diverticulitis only to deal with the complications: obstruction, abscess, generalized peritonitis, fistulae, hemorrhage, and for differentiation from carcinoma. But nowadays we are approaching the patient surgically much more often in the earlier stages, and indeed often attempting to deal radically with the matter through primary resection of the process before there can be any major complications. The thought underlying this early approach is that by dealing with the malady early you have a good chance of avoiding the last two portions of a three-stage procedure with their additional morbidities and mortalities. But I think that, while this reasoning is valid, and we have many grateful patients in whom early resections were done, one is nevertheless not entirely unjustified in looking upon diverticulitis as essentially a benign disease and bringing the utmost judgment to bear on the individual case.

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Associate Professor of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

SOME COMMENTS ON THE NEW ANTI-ARRHYTHMIC DRUGS

By NEVILLE BITTAR, M.D.
Madison, Wisconsin

IT IS NOW GENERALLY recognized that although the new anti-arrhythmic drugs including lidocaine (Xylocaine), propranolol (Inderal) and diphenylhydantoin (Dilantin) have replaced many of the time-honored drugs, they are not necessarily ideal. Thus, it is important that the practicing physician be made fully aware of not only the beneficial actions of these drugs but also of the possible hazards attending their use.

From the Cardiovascular Research Laboratory, Department of Medicine, University of Wisconsin Medical Center, Madison.

Lidocaine

Like other local anesthetic agents, lidocaine depresses myocardial activity. It is known to decrease cardiac muscle excitability, contractile strength and impulse conduction rate, and to act as a potent dilator of the arterioles. Because of these properties and the relative absence of serious side-effects, lidocaine is considered a valuable drug in the treatment of arrhythmias, in particular, ventricular ectopic beats, bigeminy and ventricular tachycardia. The drug is given intravenously and rapidly in a dose of 1–2 mg per kg body weight. Abolition of

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THERAPEUTIC DILEMMA—BECKMAN—*continued*

Only about 20% of patients—the figures vary somewhat in the different reported series—with diverticulitis ultimately require surgery if not approached by this early primary resection method. I think that in many instances if the patient is not acutely ill, one can afford to treat with antibiotics and watch the course very closely. The patient will often improve even if there has been an abscess, and we will have gained time in which to determine whether primary resection, a two- or three-stage procedure, or no surgery at all is indicated. Such a waiting period also has the advantage of providing us with a better field in which to work if surgery of some sort is found to be necessary, because it is very difficult and dangerous to perform an anastomosis in the edematous tissues in an inflammatory site. I do think that the individual who has multiple episodes of diverticulitis is a candidate for surgery, and perhaps even a second attack should be enough to designate him an individual of the type who will most frequently develop complications. Also the patient who has a small abscess that is not being well drained internally and who persists with symptoms low down in the abdomen with disturbed bowel habits, the ones with fibrosis and narrowing of the gut in the x-ray film; those with dysuria; and those of course in whom there is the least suspicion of carcinoma—are all patients in whom I recommend surgical therapy.

A newer concept regarding the surgical approach to this disease, which should probably be brought to your attention, is that of Reilly, in England (M. Reilly, *Proc Roy Soc Med* 57:556, 1964), who looks upon diverticulitis as a muscular disease and would have it approached by performing sigmoid myotomy; i.e., the longitudinal incising of the muscle of the sigmoid colon so that the contraction rings that cause segmentation are destroyed. Postoperative barium enemas have shown that this widens the colonic lumen, and restoration of normal bowel habit has been reported to occur. I have not done any of these operations, but the theoretical approach is at least attractive because many times at the table one sees evidence of muscular hypertrophy, and the gastroenterologists and pathologists both speak of this.

Dr. Franke: (Summarizing) This morning we have addressed ourselves to the vexing subject of diverticulitis. The dilemma in which we find ourselves regarding medical management of the malady has been exposed, and the lines of surgical approach to the problem have been delineated. □

the ectopic focus usually occurs within three minutes but since the effect is not infrequently transitory—the half-life of lidocaine being about 13 minutes, a continuous infusion of the drug may be necessary. In these circumstances, an intravenous infusion is administered at the rate of 1–4 mg of lidocaine per minute.

Lidocaine is without effect on atrial arrhythmias and it should not be used in patients who have heart block and who are not being paced. The side-effects of lidocaine are generally minor; these include paresthesias, light headedness, decreased hearing, euphoria, and drowsiness. The occurrence of convulsions, though very rare, usually follows the use of a large priming dose of the drug.

Propranolol

Propranolol is a beta-adrenergic blocking agent the chief actions of which are reduced cardiac muscle contractility and heart rate. The mechanism underlying the anti-arrhythmic effect of this drug is not yet known. A plausible theory is that propranolol also exerts a quinidine-like action, thereby decreasing myocardial automatism and excitability; and that through its beta-adrenergic blocking action the drug blocks the stimulating action of circulating or locally released catecholamines.

The fact remains, however, that the usefulness of propranolol as an anti-arrhythmic drug is outweighed by a number of contraindications to its use, and an equally long list of untoward effects it produces. It is thus recommended that the drug be administered only after it has been established that the arrhythmia is refractory to the other available drugs. On the other hand, propranolol can be of considerable benefit in the treatment of digitalis-induced arrhythmias, especially when used in the period immediately after withholding digitalis, or potassium-depleting drugs (e.g. thiazides, furosemide, or ethacrynic acid). Furthermore, this drug has been found to prevent the arrhythmias occurring during the period of anesthesia induction.

The experience gained in the management of patients with atrial tachycardias has shown that at least 60% of these arrythmias return to a slow sinus rhythm following the use of propranolol. In patients with atrial flutter and fibrillation, slowing down of the rate is found to take place in most instances. However, these arrhythmias seldom revert to normal sinus rhythm.

Propranolol is given intravenously or orally; when given intravenously, a dose of 1–5 mg is injected at a rate not exceeding 1 mg per minute and the heart is monitored electrocardiographically at the same time. And when given orally, 10–40 mg four times a day is considered an adequate dosage.

The contraindications to the use of propranolol are congestive heart failure, cardiogenic shock, bronchial asthma, sinus bradycardia, heart block, and severe pulmonary hypertension. The side-effects caused by this drug include nausea, diarrhea, light-headedness, vomiting, mental depression, dizziness, orthostatic hypotension, syncope, and heart failure.

Diphenylhydantoin

Like quinidine and procainamide, diphenylhydantoin reduces the excitability and automatism of the heart. However, unlike these two drugs, it does not increase the effective refractory period. Generally speaking, diphenylhydantoin is a safe drug, but disturbances in heart rate and rhythm have been reported; so have hypotension and diarrhea. Some of these side-effects might well be due to the solvent used in the parenteral preparation, since it has been demonstrated that an intravenous infusion of the solvent results in cardiac-toxicity. This action of the solvent (containing 40% propylene glycol and 10% ethyl alcohol at pH 11) can be minimized by slowing the rate of the infusion. In this connection, it is worth remembering that there are drugs, such as isoniazid, coumarin anticoagulants, phenylbutazone, and aminosalicylic acid, that inhibit the metabolism of diphenylhydantoin, and hence tend to enhance its toxic action.

The use of diphenylhydantoin is indicated in the treatment of ventricular arrhythmias and digitalis-induced atrial and ventricular tachycardias. It is also beneficial in the prevention of recurrent supraventricular or ventricular arrhythmias, but not in the control of chronic atrial fibrillation, atrial flutter or other supraventricular arrhythmias. The recommended dosage is 100 mg, given parenterally every 5 minutes, until the arrhythmia is abolished. Alternatively, a maximum dose of 1 gm can be given parenterally over a period of an hour. Should untoward effects intervene, the drug is then withdrawn. Long-term treatment of recurrent arrhythmias with diphenylhydantoin requires the use of 100 mg every 6 hours given orally. □

ERRATA

The editors wish to acknowledge two errors which appeared in the article, "Current Status of Drug Therapy in Management of Obesity," a Comments on Treatment feature, in the June 1969 (Vol. 68, No. 6, pp. 219–220) issue of the WISCONSIN MEDICAL JOURNAL.

Under Table 1 (p 220), Biphetamine should not have been identified as "amphetamine sulfate." Instead it consists of *d*-amphetamine 3.75 mg and *dl*-amphetamine 3.75 mg, both as cation-exchange resin complexes of sulfonated polystyrene.

In the next to the last paragraph in column one of that page, "Phentermine resin (ionamin)" should have read "Phentermine resin (Ionamin)." Since Ionamin is a trade name, it should have been capitalized. □

SECTION OPHTHALMOLOGY

SEPTEMBER 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

MILWAUKEE OPHTHALMIC INSTITUTE

In the late 30s, an orthoptic department was established at Milwaukee Children's Hospital and soon it became obvious that one clinic could not carry the full load of treatment of both the indigent and nonindigent cases.

In 1939, a group of 14 ophthalmologists got together and contributed $200 a piece in order to set up the Milwaukee Ophthalmic Institute whose primary function at that time was the operation of an orthoptic clinic for private patients. For the next 20 years the Institute continued to operate the Orthoptic Clinic, serving patients of all ophthalmologists in the area, as well as furnishing technicians to Milwaukee Children's Hospital. The clinic's technicians are all certified by the American Orthoptic Council, and patients are admitted to the clinic for diagnostic and therapeutic exercises only on the recommendation of an eye physician; they are treated only under his direction. The fees for this work have always been kept to a minimum, and no patient has been turned away because of lack of ability to pay.

The Orthoptic Clinic had its struggles during the war years, several times almost fading into oblivion; however, it has survived and is now one of the three or four oldest clinics in the United States in continuous operation.

In 1961, the Institute became interested in setting up a light coagulation unit in connection with the Department of Ophthalmology at Marquette. The Institute was fortunate to obtain a grant sufficient to finance this project from the Benstead Foundation of Racine. Treatment with this instrument (operated by a team of ophthalmologists) is open to all patients regardless of ability to pay.

In 1964, Dr. Richard O. Schultz assumed the position as chairman of the Department of Ophthalmology at Marquette School of Medicine. By 1966, he had assembled funds, laboratories, and competent trained personnel for research in: (1) Pediatric Ophthalmology—Dr. Otto Wiegmann, (2) Ocular Pathology—Dr. Harry Easom, (3) Ocular Surgery—Dr. Richard Schultz and Dr. E. B. Suson, (4) Infectious Diseases and Immunology—Dr. Richard Schultz, (5) Glaucoma—Dr. E. B. Suson, (6) Visual Optics—Dr. Jack Copeland. However, the department lacked the funds for equipping the laboratories, estimated at $50,000. This problem was presented to the Board of Trustees of the Institute who made a prompt decision to direct its major efforts in the future toward the support of ophthalmic research in the State of Wisconsin.

In the fall of 1966, a quiet campaign was launched to raise $50,000 to equip the laboratories listed above. In a period of about three months, from November 1966 to February 1967, approximately $60,000 was raised through various individual and foundation contributions.

On November 6, 1968, a party was held celebrating the 28th birthday of the Milwaukee Ophthalmic Institute. At the party there was a photographic display of the accomplishments of the Institute up to that date. Directly, because of the interchange of ideas at this function, the Ophthalmic Institute was instrumental in obtaining a $400,000 grant from the Faye McBeath Foundation to assist in constructing a Medical Eye and Research Facility (Clinic) which will be one of the first pieces of new construction in the developing Medical Center of Southeastern Wisconsin.

The Institute is a nonstock, nonprofit corporation, incorporated in Wisconsin; all contributions to it are deductible from federal and state income taxes.

The officers and board of trustees are as follows: John B. Hitz, MD, president; Donald B. Hughson, MD, vice-president; William B. Murphy, treasurer; S. S. Blankstein, MD, assistant treasurer; John H. Holbrook, Jr., secretary; John S. Owen, Ralph Rank, MD, Mrs. Betty Lansing, Mrs. Barbara Davidson, Henry F. Adelhauser, PhD, Mrs. Marcia Selig, and John J. Melk, trustees.

The Institute has approximately 100 annual contributing members including physicians, laymen, foundations, and industry. Annual dues are $25.

While the Institute's recent activities have been closely connected with Marquette School of Medicine, the Institute is so organized that it can work in cooperation with any other medical teaching unit within the state, including the University of Wisconsin—Madison and/or Milwaukee.—JOHN B. HITZ, MD

WISCONSIN ALUMNI MEETING

Alumni of the University of Wisconsin opthalmology residency training program will have a meeting Oct. 10 in Madison. The scientific program will consist of half-hour presentations by alumni from 9 a.m. to 5 p.m. An evening dinner is planned.

Physicians interested in further details should contact John Berger, MD, 1025 Regent St., Madison, Wis. 53715. □

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NO. 1 OF A SYMPOSIUM ON EPILEPSY

SURGICAL TREATMENT OF EPILEPSY

PRINCIPLES AND REVIEW OF PATIENTS

By FLAVIO PULETTI, M.D., Madison, Wisconsin

AN EPILEPTIC SEIZURE is the clinical manifestation of an abnormal electrical discharge of neurons in the central nervous system. The surgical treatment of this condition consists in removing, when indicated, the neurons that are responsible for this discharge without significantly increasing the neurological deficit of the patient. This is the rationale upon which surgical treatment of epilepsy is based.

Trauma, encephalitis, ischemic lesions, or birth injuries forming a cerebral "scar" are the most common causes of focal epilepsy or the attacks may be idiopathic (cryptogenic) and by the pathological methods of today the excised brain may appear normal. But epileptic attacks are also quite frequently caused by a space-occupying lesion in the brain. While in this report we are not primarily concerned with this etiology, it must be borne in mind that epileptic seizures of many years' duration may have a slow-growing tumor or a vascular malformation as their cause.

Epilepsy is a complex condition with many and variable signs and symptoms. In addition to seizures the patient may have moderate to severe neurological deficits, behavioral problems, and personality changes. The seizures and some of the symptoms that accompany them are most frequently well controlled with anticonvulsant therapy. There remains, however, a small group of patients unimproved with this type of therapy or for whom the dosage of anticonvulsant drugs must be increased to such a level that the patient becomes drowsy and incapable of functioning at an appropriate level. These are the patients for whom surgery can be considered.

The ideal result of surgical treatment (complete cessation of the seizures and improvement of the neurological or mental deficit without requiring further medical treatment) is seldom attained. More frequently one has to be satisfied with a substantial reduction in the number and severity of attacks which will permit a reduction of the dose of anticonvulsant medication. This may be accomplished by wide excision of the area where the abnormal neuronal activity is generated (epileptogenic focus) provided that this removal does not aggravate the

From the Epilepsy Center, Departments of Neurology and Neurosurgery, University of Wisconsin Medical Center. Doctor Puletti is Professor, Department of Surgery.

Presented at the 128th Annual Meeting of the State Medical Society of Wisconsin, May 15, 1968, Milwaukee.

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neurological condition of the patient and that the area is surgically accessible. This last prerequisite, however, might be modified in the future since stereotactically placed depth electrodes and the development of stereotactic surgery makes even the central masses of gray matter more easily accessible to the surgeon.

Evaluation of Patients for Surgical Treatment

In selecting patients for surgical treatment, several factors must be considered if the operation is to be successful and if the results justify the risks inherent in any major surgical procedure and especially when the brain is involved.

All patients should receive an extensive trial with anticonvulsant medications; most epileptics will obtain a very high degree of improvement with medical management alone.

The patient who responds well to medical management should not be operated upon. Although medical treatment will not always completely relieve the seizures, it is important to bear in mind that surgery cannot guarantee complete cessation of the epileptic attacks. Valuable information on the localization of the epileptogenic area can be obtained by careful history, subjective as well as objective from witnesses of the sequence of events that characterize the seizure. The history often affords an insight as to the possible etiology of the disease and should be directed toward gaining information on birth injuries, infectious diseases, trauma or anything that might suggest a space-occupying lesion. In post-traumatic epilepsy the attacks may not start during the first year after the injury; frequently the first seizure will occur several years after the accident when the cerebral scar is well formed and the condition stabilized.[1]

The ideal result of surgical treatment is seldom attained . . . surgery cannot guarantee complete cessation of the epileptic attacks.

If we are to excise the cortical area responsible for the attacks, the epileptogenic focus should be well localized. This is best accomplished by careful electroencephalographic technics including multiple recordings during sleep, pentylenetetrazol (Metrazol) activation, employing sphenoidal and nasopharyngeal electrodes. Stereotactic insertion of depth electrodes for serial recording over several days is indicated in certain cases. The focus, ideally, should be isolated in one area of the cortex, well defined, and not multiple or bilateral. The focus should also be in a part of the brain which is accessible and removable without causing any neurological deficit such as paralysis or aphasia. Occasionally, especially in desperate situations, we have operated upon patients with more than one epileptogenic focus if the clinical description of the attacks was compatible with one and only one of the foci present on the electroencephalogram.

In addition to the electroencephalographic studies patients must be thoroughly investigated with neuropsychological testing, routine skull x-ray studies, brain scan, pneumoencephalogram and carotid angiogram to uncover any possible lesion which might be responsible for the patient's disease. Psychological evaluation and IQ determination are important to determine the patient's mental and intellectual status. It may be affected considerably by the disease and mental retardation could make surgery inadvisable.[2] Strict adherence to these principles in the selection of surgical candidates will yield better results and avoid disappointment in patients who submit themselves to surgical treatment in the hope of obtaining substantial improvement or recovery from their condition.

Surgical Principles

These operations are usually performed under local anesthesia to enable the surgeon and the electroencephalographer, recording directly from the cortex, to localize the area to be excised. For localization of the area from which the seizure originates, electrical stimulation of the cortex is necessary. The attack typical for the patient may thus be reproduced or stimulation may show evidence of epileptogenic activity by evoking electrical after discharge from relatively low stimuli. Identification of the neighboring projection areas of the brain also can be accomplished. A recent introduction, helpful in this identification, is the computer-averaging technic which allows the identification of potentials elicited in the cortex by electrical stimulation of somatic sensory nerves[3] or by auditory stimuli.[4] The projection areas of course should be spared during excision of the epileptogenic focus so as not to cause unnecessary neurological deficit. In earlier years Penfield and Stillman[5] were reluctant to remove an epileptogenic focus on electrocorticographic evidence of abnormality, unless it was accompanied by an objective change in the appearance of the cortex. Following the work of Bailey and Gibbs[6] and Green et al,[7] however, such foci have been excised on the electrical evidence of an abnormality alone.

Review of Patients

The patients included in this report were referred to the Epilepsy Center of the University of Wisconsin Medical Center for the treatment of epilepsy. The admission diagnosis was epileptic seizures and no tumor or vascular anomaly had been suspected by the referring physician. It is evident from Table 1 that 4 of these patients had a space-taking lesion which was the unsuspected cause of their attacks. In 5 patients no pathologic lesion was found in the specimen excised at the time of the operation. The

pathology in the other patients varied from simple gliosis to a large porencephalic cyst. The length of postoperative followup varied from a minimum of 8 months to a maximum of 8 years. X-ray films of the skull revealed a calcified lesion in one patient while the pneumogram was considered normal in 7 and the carotid angiogram in 10.

The preoperative duration of seizures varied from 20 years in a patient in whom no pathologic lesion was found in the specimen to 4 months in a patient with astrocytoma. It is evident that the preoperative duration of seizures did not have any bearing on the results of the operation. However, many patients who at the onset of their disease may have had a well localized focus, after a few years may have acquired secondary or even independent foci as Morrell[8] demonstrated experimentally in the animal. These patients would have been excluded from consideration for surgery.

The EEG was used in all our patients to localize the epileptogenic area to be resected, unless a surgical lesion was demonstrated by arteriography or air

TABLE 1—*Summary of the patients who received surgical treatment for epilepsy*

Patient, Age, Etiol., Length of Followup	Preop. Duration and Type of Seizures	PEG	Art.	Preop. EEG Epileptogenic Focus	Epileptogenic Focus at Craniotomy	Operation and Pathology	Postop. EEG	Percentage of Improvement in Number of Seizures
1—N.A., 19 Neoplasm 4 yr.	11 yrs., psychomotor and grand mal	mass R. frontal lobe	normal	R. fronto-temporal	R. fronto-temp.	Remov. R. frontotemp. epidermoid cyst	spikes, R. frontotemporal	0%
2—J.M., 18 Neoplasm 5 yr.	10 yrs., petit and grand mal	normal	normal	L. temporal	L. temporal	L. temp. lobect. astrocytoma	no spikes	75% R. hemiparesis
3—S.G., 22 Etiol. unknown 2 yr.	20 yrs., grand mal and psychomotor	normal	normal	R. temporal	R. temp. pariet. frontal	R. temp. lobect. No pathology	spikes in L and R temporal	75%
4—C.K., 19 Neoplasm 3 yr.	14 yrs., grand mal and psychomotor	L. temporal lobe mass	L. temporal lobe mass	L. temporal	Corticog. not done	Part. remov. L. temp. glioma in tuberoscl.	Delta waves L. temporal	100% Comm. Hydro. treated by shunt
5—H.G., 17 Etiol. unknown 3 yr.	15 yrs., grand mal and psychomotor	normal	normal	L. superior frontal and temporal	L. frontotemporoparietal	L. frontotemporopar. expl. Biopsy not taken.	same as preop. (no excision)	0%
6—R.E., 9 Post encephal. 2 yr.	7 yrs., psychomotor	atrophy, R. frontoparietal	abnormal vessels, R. frontoparietal	Temporoparietal bilateral	Corticog. not done	R. parietofront. expl. Numerous dilated vessels.	spikes, R. temp. and hilat. pariet.	0%
7—V.F., 29 Etiol. unknown 8 mo.	14 yrs., psychomotor	atrophy R. hemisphere	normal	R. temporal	R. temporal	R. temp. lobectomy. No path.	not available	100%
8—M.C., 16 Etiol. unknown 9 mo.	14 yrs., multiple types	Unsatisfactory	normal	L. temporofrontoparietal	Temporofrontoparietal	L. temp. lobectomy. No path.	highly abnormal	0%
9—D.L., 47 Etiol. unknown 12 mo.	18 yrs., psychomotor	normal	normal	R. temporal	R. temporal	R. temporal lobect. No path.	no spikes	75%
10—R.P., 51 Neoplasm Died 1 yr. later	4 mo., focal R. face and hand	small deformity R. frontal horn	normal	R. fronto-temporal	R. frontal	Remov. R. frontotemp. astrocytoma grade II	bilateral slow waves, R. more than L.	75% L. hemiplegia
11—J.K., 18 Neoplasm 7 yr.	1 yr. grand mal	L. frontotemporal mass	L. fronto-temporal mass	Frontotemp. bilateral	Corticog. not done	Remov. L. frontotemp. meningioma	no spikes	100% after 3 postop. seizures
12—K.B., 8 Post encephal. 8 yr.	7 yrs., grand mal and Jacks. (L. arm, leg)	marked R. atrophy	not done	Generalized	R. frontal (widespread)	R. frontal lobect. Scar tissue	highly abnormal on the L.	0%
13—H.B., 34 Etiol. unknown 3 yr.	23 yrs., psychomotor	normal	normal	R. anterior temporal	R. anterior temporal	R. temp. lobect. Astrocytosis	dysrhythmia Grade I	75%
14—M.K., 23 Etiol. unknown 6 yr.	14 yrs., grand mal	normal	normal	Generalized more on R. temporal	R. temporal	R. temp. lobect. Astrocytosis	spikes still present R. side	25%
15—J.G., 55 Postencephal. 8 yr.	10 yrs., grand mal and psychomotor	R. temp. porencephalic cyst and generalized atrophy	not done	Bilateral temporal	R. temporofrontoparietal	Excision of R. temporal porenceph. cyst	spikes, L. temporofrontal	0%
16—B.B., 30 Post-traum. 3 yr.	25 yrs., psychomotor	R. hemisphere atrophy	R. hemisphere atrophy	R. temporal	R. temporofrontoparietal	Temp. lobect. R. temporoparietal porenceph.	no spikes	75%
17—J.H., 22 Tuberoscler. 2½ yr.	5 yrs., Jacksonian	normal	normal	R. parietal	R. parietal	Remov. nodule R. pariet. lobe	no spikes	100%
18—W.S., 26 Etiol. unknown 15 mo.	9 yrs., psychomotor	normal	normal	R. temporal	R. temporal lobe	R. temp. lobect. No path.	normal	50%

studies. Eight of our patients had a unilateral temporal focus, 1 had a well defined focus on the right parietal region and in 9 patients the epileptogenic activity was widespread.

From the analysis of Table 1 it is evident that when this epileptogenic activity arises from a well circumscribed area, the results are much more rewarding than when it involves two or more lobes. In our limited series of 9 patients who had a circumscribed focus, 8 had an improvement of 75% or more and only 1 had a reduction of only 50% in the number of seizures. Conversely only 2 of the patients with an epileptogenic area involving more than one lobe had a significant improvement while the other 7 were either unchanged after the operation or had minimal improvement.

Absence of any pathological changes in the tissue removed at the time of operation did not seem to bear any relation to the results of surgical treatment. In 1 patient, however, the biopsy was not taken because the electrocorticographic focus involved the sensory motor and Broca's area. Four patients who were selected for surgery because of well localized temporal epileptogenic activity did not show any abnormalities on microscopic examination of the anterior temporal lobe. Two of them had a reduction of 75% in the number of seizures, 1 of 50% and the fourth patient may be considered completely cured. However, because of the limited number of patients, the data are not statistically valid.

The best results have been obtained in patients with psychomotor epilepsy and temporal lobe resection.

Neither the duration of the disease nor the presence of lesions demonstrated by pneumogram or angiogram seemed to have any influence on the success of the operation. The only factor constantly associated with good results was a sharply defined epileptogenic focus in the preoperative EEG which was confirmed by direct recording from the exposed cortex at the time of surgery (electrocorticography). This confirmation was obtained in all but 3 patients on whom electrocorticography was not done because their pathology was clearly evident and profuse bleeding was present from the lesion upon opening the dura mater.

While our procedure has been to excise the entire epileptogenic cortex, the sensory motor cortex or the speech areas have been spared even when they were included in the focus. In these patients, of course, improvement was minimal if any.

A strict correlation exists between the absence of epileptogenic activity in the postoperative EEG and the degree of improvement. Of 9 patients who had 75% or more reduction in the number of seizures only 1 still has some spikes present in the postoperative electroencephalogram. We have operated on patients with rather widespread epileptogenic foci only when the number and the severity of their attacks made the patient totally incapacitated and when all the available medical means had failed. Surgery was done in the tenuous hope of finding a better defined focus on the cortex after exposure, which could be consistent with the clinical localization of their attacks. This, however, has not been the case and in such instances the results have been most disappointing.

Two patients became hemiparetic and one developed a communicating hydrocephalus that required a ventricular atrial shunt after surgery. All 3 patients had a glioma in the temporofrontal area as the cause of their seizures.

Conclusions

From observation of our data one can reaffirm the following:

1. The most valuable indication for surgery is a well localized and sharply defined electroencephalographic epileptogenic focus in an area of the cortex surgically accessible and not involving projection or speech areas.

2. Preoperative duration of the disease should not be a factor in the selection of these patients.

3. Contrast diagnostic studies should be done preoperatively since some of these patients may have space-taking lesions, vascular anomalies, or atrophy as the underlying cause of their seizures. Patients 1 and 2 in Table 1 show how a tumor may be present for as long as 10 years without causing any signs of increased intracranial pressure.

4. In the postoperative evaluation of the patient the best results are to be expected when the electroencephalogram has returned to normal.

5. The best results have been obtained in patients with psychomotor epilepsy and temporal lobe resection.

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CLINICAL THERAPEUTIC CONDITIONING IN EPILEPSY

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ONE OF THE peculiarities of epilepsy is its episodic nature. A physician can readily understand the occurrence of seizures in a given brain disease such as atrophic lesions, brain tumors and post-meningeal scars. But, what determines the frequency and the actual occurrence of seizures at a particular time? Biochemical studies have been carried out over a quarter of a century attempting to determine this. While much headway has been made from the original acetylcholine studies, there still is no given explanation for the sudden excessive electrical discharge of the gray matter.

However, there is one group of patients in whom the triggering mechanism is quite obvious. The mechanism is primarily physiologic. This group of patients is called the sensory-evoked epilepsies.[1] The most frequently encountered are the photic-induced, in whom flashing lights provoke seizures, usually petit mal but sometimes major motor in type. Other types of evoking visual stimuli include the viewing of patterns and even eye closure. In the auditory sphere the most common are the so-called acousticomotor or startle epilepsy, evoked by hearing a sudden loud noise, and usually myoclonic jerks but sometimes focal progressing to grand mal seizures. A surprise element is necessary for if the patient sees an object falling, the noise of the impact will not evoke a seizure. There are more complex types of auditory-evoked seizures, for example, musicogenic epilepsy induced by certain notes or certain types of music. The rarest of all the auditory evoked is the voice-induced epilepsy where certain voice patterns evoke seizures. Reading epilepsy is one of the more complex types of sensory-evoked epilepsy where reading printed material evokes a seizure. An extremely rare type is the somatosensory evoked where a sudden brisk tap on a particular part of the body evokes a seizure.

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In 1958 while chairing the Exchange Mission to the U.S.S.R. for our U.S. P.H.S., it occurred to the author that sensory-evoked seizures might indeed be a conditional reflex, that is, that a stimulus such as flashing lights which to most people is a neutral stimulus somehow acquired the characteristic of a conditioning stimulus and therefore the resulting seizure is a conditioned reflex. To test this theory, a series of studies was carried out in cats and it was found not possible[2] to induce a conditional seizure to flashing lights or sudden noises by true Pavlovian techniques unless the cat was rendered epileptogenic. After three years of work with animals the techniques were sufficiently perfected that they could be applied to patients.

A series of clinical studies over the past seven years has led to the development of conditioning techniques for the alleviation of sensory-evoked seizures in patients. Various techniques necessarily had to be developed for the various types of sensory-evoked reflex epilepsy.

In all types, however, the fundamental concept of the conditioning technique is the application of the stimulus, for example flashing lights, altered to render it innocuous and approaching the noxious level of stimulus or conversely the employing of relatively refractory periods of the epileptogenic brain for the delivery of the unaltered and noxious stimulus. In other words, the entire technique depends upon employing either threshold of stimulus or threshold of excitability levels in such a way that the stimulus does not evoke a seizure or a dysrhythmia.

In photosensitive patients only the technique of modifying the stimulus has been effective. In our observation we have not been able by repeated stimulation through induced seizures to produce a relatively refractory period. This is probably because the seizures induced were petit mal and immediately after the seizure the patient returned to a complete state of consciousness without post-ictal slowing of the electroencephalogram (EEG). The mechanisms for changing the presentation of stimuli consisted of monocular presentations,[3] or the control of ambient room light[4] beginning with the ambient light so high (600 foot candles at the bridge of the patient's nose) that the stroboscope was barely perceptible and gradually decreasing the room light to the point of

complete darkness. Another technique which was only occasionally employed was beginning stimulation outside the frequent sensitive frequency range, for example, patients sensitive between 15 and 35 cps would be stimulated at 12 cps, 14, 16, and so on, thus moving from the refractory range.

Both the monocular presentations and the control of ambient room light techniques literally punch a hole in the spectrum of sensitivity. For example, if the patient is sensitive between 15 and 35 cps, treatment at 20 cps will render stimulations between 17 and 22 or 23 cps innocuous. Other techniques could be employed as the distance between the stroboscope and the patient or the use of filters of different colors. These, however, would be more difficult to automate and alteration in the light intensity has proven the most successful for deconditioning.

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Because of the large amount of time involved and the need for making rapid decisions upon evocation of a dysrhythmia (if the stimulation is continued for about 0.4 second after the dysrhythmia appears, seizure may ensue with resultant decrease in the effectiveness of the therapy), it was found expedient to computer automate the process.[5] This was accomplished by linkage through two data phones to the Cybernetics Laboratory. Over one data phone signals were sent by the Cybernetics Laboratory for programming and these controlled the stroboscope and the ambient room light. Over the other data phone, the patient's brain waves were sent to the computer and monitored by it. Upon the appearance of dysrhythmia the ambient light was increased and the process was repeated and thus completely automated.

Pattern epilepsy[6] was also treated by monocular stimulations and by ambient room light change. However, in this case the presentation of pattern began in a very dim light and the light was gradually increased. A simpler method is to project the patterns by a lantern slide and have these patterns out of focus and gradually brought into focus. Any, or combinations, of these three techniques, monocular presentations, progressively bright light, or a progressively better focus, can be employed. Eye closure seizures[6] can be treated by putting the patient in a completely darkened room and gradually increasing the room light so that a level of 600 foot candles can be reached without difficulty.

In startle epilepsy,[7] the noxious sounds can be presented by means of stereo earphones and tape recorder into each ear separately or binaurally at levels below the noxious level with a gradual increase of the stimulus above the noxious level.

In musicogenic epilepsy, the noxious music can be presented in a form in which it is innocuous. For example, some of the patients with musicogenic epilepsy will not have seizures to a particular noxious number when rendered on the piano, computer, or organ but only with combinations of instruments or instruments and vocalist. There can be a gradual introduction into the music of the multiple instrumentations. This, however, is exceedingly time-consuming; and although we showed it was successful in our first musicogenic patient,[8] this method was abandoned in favor of a simpler method using the post-ictal refractory period. This consists of playing the noxious number and evoking either a seizure or dysrhythmia and continuously replaying the music. If this is replayed during the ictal and post-ictal period, there is no return of seizures on subsequent replaying.[9] The same process was used in the patient with voice-induced epilepsy. That is, the playing of the tapes of the radio announcers to whose voice she was sensitive and replaying ictally and post-ictally.[10]

In one case of somatosensory epilepsy,[11] the somatic area was carefully delineated. It consisted of right thigh and hypogastric region. Sudden, unexpected tapping of this area evoked a seizure. Methods of treatment consisted of beginning to tap outside this region and moving into it, or within this region beginning with innocuous, very light tapping and gradually increasing the strength of the stimulus. Repeated taps with the patient observing the first few taps administered and then closing her eyes while additional taps were given were innocuous. Tapping at a frequency of 4 to 6 per second for a minute produced a refractory period of 4 seconds and this refractory period was increased by repeated stimulations. By this type of conditioning a temporary refractory period could be obtained in all types of sensory-evoked seizures.

There is, however, a specificity to the refraction. For example, in startle or acoustico-motor epilepsy the conditioning of the patient to tolerate the sound of a bell rendered similar bell sounds innocuous yet other noises such as rifle shots or buzzers were still noxious and indeed dissimilar bells were still noxious. The conditioning process has to be carried out for a parameter of sensory stimuli that has to be determined in a given patient.[7]

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While there is a specificity of response, there is also generalization. For example, one of the musicogenic patients in whom we did the laborious process of synthesizing, full orchestrations of a particular number became innocuous to all similar full orchestrations of that number.[8]

However, therapeutically, the process is temporary and it is necessary to determine methods for reinforcement of the therapeutic conditioning on a day-to-day basis. Several patients with startle epilepsy were given tapes of all the noises which evoked seizures in the laboratory and to which they had been conditioned. These they listened to at home on a tape recorder or if their home was equipped with an inter-communication system, this was even more practical since the sound was heard wherever they were in the house and it had more of a startle component. The same was used in the musicogenic[8,9]

and voice-induced[10] cases where the appropriate music or voices to which the patient had been conditioned were placed on tapes and listened to twice a day. In the visual group, the photosensitive patients[12] most have been fitted with special glasses which have a photo-electric cell over the bridge of the nose which activates a hearing-aid device in the ear piece of the glasses. During the process of the conditioning therapy in the laboratory, they wear these glasses and are given numerous innocuous light flashes associated with clicks in the conditioning process and gradually proceeding into the noxious stimuli. This, therefore, is a process which transfers the conditioning to a second signal system and serves two purposes. The patient in a day-to-day environment is protected from sudden changes in light intensity by an audible click which is now a second signal system in conditioning. By simply looking at a bright light each day and rapidly passing his fingers in front of the photo-electric cell and his glasses, he produces a stroboscopic effect associated with the clicks so that in this way there is daily reinforcement of the conditioning process. One of the patients whose photosensitivity was not severe, and for practical reasons, would not wear the glasses and another was the first patient we treated before we had designed the glasses. These patients were given soft velvet patches to cover one eye and daily have monocular stimulations at home and thus maintain their conditioning.

We are presently experimenting on the process of placing in a super 8 mm cartridge type of a projector a 5-minute film of the patterns to which the patient has been conditioned. These films begin in darkness and out of focus for the first 3 minutes and end with a 2-minute period of sharp, bright presentation of the pattern. It is not yet certain whether this can be used for the reinforcement of the clinical therapeutic conditioning of pattern epilepsy.

In the somatosensory epilepsy, the matter of reinforcement was somewhat more difficult. A second signal system was employed also and it was possible to associate the tapping of the thigh with an audible click. A special switching device was designed to cover approximately one-quarter of the sensitive area. This consisted of two layers of plastic with a grid and a soft sponge between it. Impact on the interfacing metallic points closed the grid and the switch. A wire led from the switch to a hearing aid device worn over the right ear. On impact with objects this produced a click and affords a protective element to the patient. The patient self-stimulates this area repeatedly daily by tapping on the switch and evoking the clicks to maintain the conditioning.

Summary

This paper reports our studies in a large group of sensory-evoked epilepsies and the effect of clinical therapeutic conditioning in this type of epilepsy. These patients have been refractory to medication and no changes in medication were introduced during the process of the conditioning or the subsequent maintenance of conditioning. This is a laborious and time-consuming work. The introduction of computer automation into the therapy of photosensitive patients makes possible a more pragmatic approach both in the matter of time involved by the patient and the amount of special attention necessary by the investigator.

The term "clinical therapeutic conditioning"[13] has been used to designate this type of therapy. Certainly it is in the general school of conditioning and learning processes. It is not true Pavlovian conditioning with a condition stimulus coupled to an unconditioned stimulus and after repeated trials the conditioning stimulus evokes the unconditioned response. This is rather the problem of conditioning away an abnormal unconditioned response. For example, music produces in these patients an abnormal unconditioned response (a seizure) and the conditioning consists in presenting altered unconditioned stimulus as a conditioning stimulus. The ultimate aim and goal of the conditioning is the removal of the abnormal unconditioned response. It is a predictable response which applies to other clinical problems in neurology.

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CLINICAL DIAGNOSIS IN EPILEPSY

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EPILEPSY HAS BEEN defined as a group of conditions characterized by recurring convulsions. From the time that records have been made on the illnesses of man, epilepsy has formed a prominent part. The theories of its origin were a mixture of magic and religious fantasy and according to Thomas Willis (1684) the early approaches to treatment frequently did more harm than good. Indeed, Antonius Guainerius wrote, early in the 15th century:

> "Place a wooden peg between his teeth . . . and also when an epileptic falls, at once kill a dog, giving the gall to the patient in any way you can. If the one who first sees the attack urinates in his own shoe, and then stirs it around as if to wash it, then gives it to the patient to drink, afterwards, the patient will be entirely delivered."

The epilepsies compose a group of disorders in which the common factor is a paroxysmal, excessive, neuronal discharge within the brain. It is accompanied by a sudden disturbance of function of the body or mind. The disturbance, whether it is loss of consciousness, disturbance of the mind, excess or loss of muscle tone or movement, disorders of sensation, or special senses or disturbances of the autonomic functions of the body, is subservient to the part of the brain involved.

The basic disorder of the epileptic neurone lies in the instability of the cell membrane. It results in an excessive or prolonged neuronal discharge due to excessive depolarization and possibly repolarizing and hyperpolarizing mechanisms. Membrane stability and polarization are intimately related to ionic balances across the membrane and to mechanisms of oxidative metabolism. In addition to intrinsic mechanisms, extrinsic factors contribute to the epileptogenic neurone or neurones; namely, excessive bombardment of cells by impulses arriving over fiber pathways from a distance, and alterations in the chemical environment of cells due to systemic metabolic changes or disorders.

Symptomatic Classification

Many attempts have been made to classify seizures as they occur in the patient, but there has been no universal agreement.

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For the layman on the street, it is sufficient to describe the generalized tonic-clonic seizure as a convulsion or a fit. For the orderly in a hospital, it may be sufficient to say that a patient had a major or a minor seizure. Indeed, such observations have been most useful in some drug studies carried out in hospitals for epileptics. We, as physicians, must go further and describe the seizure accurately according to an accepted classification. Dr. Francis McNaughton and I suggest the following classifications. The classification is purely symptomatic, there is no reference to where the seizures originate anatomically, such as "temporal lobe seizures," nor is there any reference to the electroencephalogram or the cause. We feel these things should be classified separately.

I. GENERALIZED CONVULSION (seizures generalized from the onset)
- A. GENERALIZED TONIC–CLONIC
- B. MYOCLONIC—Myoclonic jerks
  —Massive spasm
- C. ATONIC (Salaam or Drop Fits)

II. LOSS OR DIMINUTION OF CONSCIOUSNESS WITHOUT GROSS MOTOR COMPONENT
- A. ABSENCE SIMPLE
- B. ABSENCE WITH MINOR MOTOR ACCOMPANIMENT
- C. ABSENCE WITH AUTOMATISM

III. LOCALIZED ONSET WITH OR WITHOUT LOSS OF CONSCIOUSNESS (based on initial event)
- A. MOTOR
- B. SENSORY
- C. APHASIC
- D. AUTOMATISM (Apparently Integrated, Purposeful, Activity with Amnesia)
- E. PSYCHICAL (Delusions, Hallucinations, Deja Vu, Forced Thinking)
- F. AUTONOMIC

IV. UNCLASSIFIED

Most people can recognize a generalized tonic-clonic seizure. It should be remembered that frequently such a seizure may start off as a localized seizure, motor or sensory, which spreads to involve the rest of the brain. In such a case, the seizure should be classified as a localized which spreads to become a generalized tonic-clonic seizure. Myoclonic seizures may be localized jerks, either sporadic or continuing, or one may have the massive spasms, in which the whole body is involved. It is sometimes difficult to distinguish atonic seizures or drop fits from a massive spasm.

The second major group, "Loss or Diminution of Consciousness without Gross Motor Component," covers the *absence seizures*. Originally, in the French literature the term "petit mal" was proposed to cover all types of minor seizures. Later, the term "absence" was proposed to cover the very transient loss of consciousness associated with a blank stare. Since then, the two terms have caused a great deal of confusion. We generally find that the general practitioner uses the term "petit mal" for most any type of minor seizure, which indeed is the correct usage according to the early French literature, whereas the neurologist has tended to use the term "petit mal" for a type of absence associated with the 3-per-second wave-and-spike abnormality on the electroencephalogram. In order to avoid this confusion it has been proposed that the term "petit mal" be dropped in favor of the word "absence." A group of us working together in the Collaborative Study of Epilepsy defined the "absence simple" as follows:

> "The seizure begins suddenly with an alteration or a loss of awareness and/or responsiveness without gross convulsive movements. There may be, in addition, what is clinically termed a blank stare, brief upward rotation of the eyes, interruption of activity, and maintenance of posture. It ends quickly. It is usually brief but may vary in duration."

We recognize that other phenomena may accompany this simple absence and following the lead of the classification proposed by the International League Against Epilepsy, the World Federation of Neurology, and the International Federation of Societies for Electroencephalography and Clinical Neurophysiology, a second group was established. This was the absence with motor manifestations. Those of us working in the Collaborative Study of Epilepsy subdivided this into five groups. However, we have found over the past two years that the groupings are awkward and we further simplified to:

A. ABSENCE SIMPLE
B. ABSENCE WITH MINOR MOTOR ACCOMPANIMENT
C. ABSENCE WITH AUTOMATISM

A third major group includes those seizures with a localized onset with or without loss of consciousness. They may remain localized or spread to involve the rest of the body and become a generalized convulsion. These have been divided into six groups: motor, sensory, aphasic, automatism, psychical, and autonomic. We emphasized before: the essential thing is where or how the seizure starts.

The fourth group includes those seizures which for one reason or another cannot be classified. Usually, this is because the seizure has not been observed by a competent witness, or the events may take place so quickly that the observer feels unable to classify accurately what he saw.

Duration of Seizures

You will notice in this classification that there is no mention of status epilepticus or absence continuing. There is a feeling that in each attack the duration should be indicated and described as being:

(1) very brief—of the order of 1 second,
(2) brief—of the order of 10 seconds,
(3) long—of the order of 1 minute or more,
(4) prolonged or continuing—of the order of 1 hour or more.

Thus, a prolonged or continuing generalized tonic-clonic seizure would replace what is generally referred to now as status epilepticus, and the term "petit mal status" would be replaced by—absence continuing.

Precipitating Factors

Many seizures are characterized by the factors which precipitate them. Among these are television, sunlight flickering through the trees or reflected from the water, self-induced visual flickering such as a child who looks at the sun and passes his fingers in front of his eyes, auditory stimuli, startled reactions, sleep, sudden arousal from sleep, hyperventilation, and other miscellaneous stimuli.

We have considered some of the aspects of the clinical classification of epilepsy. One should remember that the seizure itself is a symptom of an underlying disorder of the brain which may be structural, chemical, physiological or a combination of all three. The basic physical chemical phenomena that take place may be common to all seizures but the cause varies from patient to patient.

Age

Age plays a role in the changing pattern of seizures. As an infant develops, the type of seizure changes. The newborn has myoclonic jerks, the infant may develop massive spasms, the child absence attacks, and the adolescent generalized tonic-clonic convulsions. As the brain matures, resistance to seizures increases and seizures become less frequent. This is why seizures are ten times more common in children than in adults.

The Causes of Epilepsy

It would be impossible to review all of the different causes of epilepsy. Some of the specific causes play a particularly important role either because they are the cause of the seizures in many patients with epilepsy or because they involve a specific pathophysiological mechanism that leads to seizures.

Genetics

Early in the century, epilepsy was divided into two types, idiopathic and symptomatic. The term "idiopathic" inferred that the cause was not known, the brain was structurally intact, and heredity was an important contributing factor. Other terms meaning the same thing such as "cryptogenic," "essential," and "genetic" were used. "Symptomatic" inferred a type of epilepsy where the cause was known. The attitude today, in the light of the most

recent genetic studies, is that a genetic or hereditary factor is present in all of the epilepsies. The greater this factor the more likely are seizures to occur in a specific cerebral disorder.

The most comprehensive study on the genetic aspects of epilepsy is that being carried out by Metrakos and Metrakos[1] in Montreal. They had studied approximately 1,200 families of epileptics and 400 control families, as well as more than 3,000 electroencephalograms on patients, parents, and siblings.[2] Their findings clearly demonstrate a familial distribution of convulsions. Without giving all of the evidence, it would appear that if due allowance is given for the variability of age at onset of the centrencephalic type of EEG abnormality and also for its tendency to disappear in later years, the data which these investigators collected are compatible with the hypothesis that an autosomal dominant gene is responsible for the centrencephalic EEG. More recently, Metrakos and Metrakos have tested offsprings and nephews and nieces of centrencephalic patients and the dominant hypothesis appears to be holding true. Their further work also suggests that in children with infantile hemiplegia, seizures are more frequent in those with a positive family history. This and other studies suggests there is a hereditary factor in all types of epilepsy.

The seizure itself is a symptom of an underlying disorder of the brain which may be structural, chemical, physiological or a combination of all three.

Perinatal Factors

Birth trauma and asphyxia neonatorium are two of the most important causes of brain damage with subsequent epilepsy.

The work of Windle[3] and his colleagues has led to a further understanding of the role of asphyxia in the newborn as a cause of cerebral damage. They found that newborn monkeys need not be asphyxiated to the point of terminal apnea in order to suffer structural brain damage. Asphyxia neonatorum requiring resuscitation of the offspring, which otherwise would die, was associated with a remarkably constant syndrome of bilaterally symmetrical, nonhemorrhagic lesions in thalamic and brain-stem nuclei, mainly those of afferent systems. The monkeys in this second category were clearly retarded mentally and demonstrated associated postpartum complications leading to neocortical atrophy, often of considerable magnitude. They were not only remarkably retarded but also often palsied, epileptic, and in some instances even comatosed.

Infectious Diseases

Convulsions may herald the onset of meningitis or may appear years after the illness. Seizures during the onset and acute course of the disease may be due to localized cortical, venous or arterial occlusion; they may be due to the "toxic" state, or the fever alone may precipitate the attack. Seizures of late onset are generally secondary to the meningocerebral cicatrix.

The most common sequelae of viral encephalitides are disturbances of movement, sleep, behavior or intelligence, but seizures are common. The type of seizure depends somewhat on the degree of maturation of the brain. Myoclonic massive spasms, focal motor attacks, absence or generalized convulsions have all been described.

Febrile Convulsions

Febrile convulsions present a special problem in epilepsy. There are children who have convulsions associated with fever only. They have normal electroencephalograms between seizures and appear normal on neurological examination. The attacks disappear as the child grows older. This is what may be called true "febrile convulsions." Unfortunately, many children who have their first seizure associated with a fever may have subsequent seizures not related to an elevated temperature, or they may have demonstrable cerebral abnormalities and fever tends to precipitate an attack.

Metrakos and Metrakos[2] found that 106 children whose first convulsion was labelled "febrile," 63% had additional convulsions. Of those with additional convulsions, 36% had convulsions other than febrile. They also showed that there was a strong genetic factor in "febrile convulsions." Approximately 10% of the siblings of children whose first convulsion was febrile, themselves had convulsions. One is led to agree that "threshold genes" play a significant role in the occurrence of febrile convulsions.

The role that febrile convulsions associated with excessively high fever play in producing mental retardation, hemiplegia or persistent epileptogenic foci, particularly in the hippocampal region, warrants further study. Insufficient attention has been paid to the brain damage that excessive, prolonged fever and convulsions can cause. A temperature of 107 F probably causes the convulsions which, in turn, produce focal or diffuse cerebral anoxia and irreversible changes.

Toxic Factors

There are specific drugs known to affect the polarization of cell membranes sufficiently to produce convulsions. Pentylenetetrazol (Metrazol) is the outstanding example. This is used as a means of activating electroencephalograms and provides a useful means of testing the anticonvulsant properties of certain drugs. There are many toxic substances that affect the brain sufficiently to produce convulsions. The mechanism varies with different groups

In this day and age it is surprising how few patients one sees that are truly idiopathic and where no cause can be found. With the tools and anticonvulsant remedies available, most patients with epilepsy can be helped.

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of compounds or conditions. Some have a direct effect on the metabolic activity of the neurone and its conducting apparatus. Strychnine is an example of this. Other compounds produce convulsions on their withdrawal. This is seen in alcoholism or certain types of drug addiction. Others exert an indirect effect by causing an impairment of circulation as in lead poisoning.

Alcohol

Alcohol, or the withdrawal from it, is one of the most common causes of convulsions after the age of 30. Rhinehart[4] found a 10% incidence of "rum fits" in an alcoholic population from a review of 200 consecutive patients admitted to a state mental hospital. He believed that the incidence actually is higher.

Seizures frequently occur at the onset of dilirium tremens. Victor and Adams[5] found 30 patients with seizures among 101 consecutive patients with delirium tremens. Isbell *et al*[6] showed that symptoms such as nausea, vomiting, tremor, hallucinations, and delirium tremens are precipitated by a reduction in the blood-alcohol level. The symptoms of delirium tremens and convulsions are closely related, and their severity depends on the length of time and amount of alcohol taken before withdrawal. Many authors state that the withdrawal symptoms are due to malnutrition and vitamin deficiency. It has been shown, however, by Victor and Adams, that the symptoms occur despite the ingestion of an adequate diet and supplemental vitamins throughout the period of intoxication and withdrawal. Pluvinage and Lelus[7] demonstrated a pyridoxine deficiency in 113 cases of alcoholism, although there was no correlation between this and the severity of the clinical picture. For the present it must be stated that the exact biochemical phenomena associated with the alcoholic withdrawal syndrome are not known.

Allergic Reactions

It is not an uncommon story that a child receives a "booster shot" of typhoid, poliomyelitis, diphtheria, pertussis, and the like and shortly afterwards has a convulsion that may leave a residual hemiparesis. This may be transient or permanent. It is highly probable that there is a vascular occlusion associated with the hemiparesis. Some of these have been demonstrated by arteriography; however, more frequently than not, nothing abnormal is seen. It has been postulated that there is some type of allergic reaction, causing localized vascular spasm or occlusion, that accounts for the hemiparesis and the convulsion is secondary to the encephalomalacia. Another suggestion is that the hemiparesis is a postictal Todd's paralysis, due to "exhaustion" of the involved area of the cortex. Regardless of the pathogenesis such phenomena do occur and constitute a calculated risk in any program of mass immunization.

Metabolic and Nutritional Disorders

The importance of metabolic and nutritional disorders as a cause of epilepsy has been known for a long time. It is only recently, however, that any real knowledge of the role they might play has been demonstrated. A good example is pyridoxine or Vitamin B6 deficiency or dependency. It has been shown that pyridoxine plays an important role in the production of gamma aminobutyric acid, GABA, an inhibitory substance, the lack of which interferes with the sodium ratio and permits seizures to take place. Disorders of electrolyte and water balance are closely related to seizures in infancy during periods of hydration and dehydration and are undoubtedly related to the shift of sodium and potassium across cell membranes. One is reminded of the hydration test to bring out abnormalities in the EEG or to precipitate a convulsion as a means of studying the seizure pattern. Physicians continue to advise patients against drinking too much water.

These are some of the more important causes of seizures. However, we should not forget trauma, tumors, heredofamilial degenerative diseases and many other disorders of the brain which may lead to the excessive abnormal neuronal discharge.

Seizures are, in a sense, a physiological disturbance. They can be elicited in a normal brain by chemical or electrical stimulation. In abnormal brain tissue, as a rule, the threshold for seizures is lower and attacks are more readily produced by chemical or electrical stimulation. In the normal brain there is a certain stability between the processes of excitation and inhibition. However, in a seizure, it is considered generally that the balance is lost in favor of excitation. Current investigation suggests that convulsive activity is not an enhancement of the normal excitation of neurones but a partial, or complete, block of normal inhibition. A biological abnormality of some neurones is thought to underlie the initiation of a gradually increasing depolarization in their dendritic fields, so that minimal stimuli may initiate a seizure discharge. In any case therapy is directed at increasing the stability of the neuronal tissue. A seizure originating in an area of abnormal cerebral tissue may remain localized or it may spread to involve normal brain cells. If the spreading electrical activity is sufficiently extensive, the whole brain and spinal cord become involved and a tonic-clonic seizure ensues.

Summary

In the clinical evaluation of a patient, one first endeavors to determine from the patient and relatives the description of the seizures and the factors that may be contributing to their cause. The history and physical examination are most important. One proceeds then to x-ray studies of the skull and chest, and other laboratory tests as indicated. The electroencephalogram is a subject in itself, and will be discussed later in this program. In this day and age it is surprising how few patients one sees that are truly idiopathic and where no cause can be found. With the tools and anticonvulsant remedies available, most patients with epilepsy can be helped.

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NO. 4 OF A SYMPOSIUM ON EPILEPSY

NEUROPSYCHOLOGICAL EVALUATION OF THE EPILEPTIC PATIENT

By HALLGRIM KLOVE, Ph.D. and CHARLES G. MATTHEWS, Ph.D.
Madison, Wisconsin

CLINICAL NEUROPSYCHOLOGY is a specialty area within psychology which is concerned with brain-behavior relationships in humans. Research and clinical problems with which the neuropsychologist is concerned include the identification and classification of patterns of psychological test performances as they relate to location, type, and extent of cerebral lesions, and the investigation of patterns of behavioral deficits as a function of central nervous system disease or injury incurred in infancy, in childhood, or as an adult.

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From the Neuropsychology Laboratory, Department of Neurology, University of Wisconsin Medical Center. Doctors Klove and Matthews are Associate Professors of Neurology. Doctor Klove also is Director of the Neuropsychology Laboratory.

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Because of these research and clinical interests, the neuropsychologist necessarily is also concerned with the relationship between neuropsychological methods for evaluating the organic integrity of the cerebral hemispheres and the various clinical, electrophysiological and radiological procedures that neurologists employ in their diagnostic evaluations.

The test battery used in our neuropsychology laboratory can be divided into three major categories. One category consists of conventional tests of psychometric intelligence, primarily the Wechsler Adult Intelligence Scale.[1] In addition to yielding IQ estimates, the Wechsler Scale permits the identification of any differentiated intellectual impairment which may be present, and such information may contribute in an important way to inferences regarding lateralization of cerebral damage or disease.[2]

A second major category of tests is represented by a group of measures selected from Halstead's battery of neuropsychological tests.[3] Each of these tests has been shown to be highly sensitive to pres-

TABLE 1—*Descriptive Variables*

		N	Sex	Age	S.D.	Ed.	S.D.
Group I	Control	51	M 31 F 20	33.49	10.09	11.53	2.74
Group II	Verified brain damage without epilepsy	51	M 41 F 10	34.88	13.24	10.63	2.62
Group III	Verified brain damage with epilepsy	51	M 43 F 8	34.65	10.37	10.51	2.87
Group IV	Epilepsy of unknown etiology	51	M 32 F 19	31.67	9.62	11.23	3.53

ence of organic brain damage.[3-5] This section of the test battery samples a broad range of adaptive abilities including abstraction-concept formation, complex psychomotor problem solving, attention, memory, and sensory discrimination processes.

A third group of measures includes tests which permit precise quantification of motor and sensory abilities on the two body sides, with particular emphasis upon identifying any asymmetries which may be present in the individual patient protocol. Motor and sensory abilities routinely examined include finger tapping speed, grip strength, and fine dexterity and coordination as well as testing for imperception phenomena in tactile, auditory and visual sense modalities. Finger localization and tactile form discrimination abilities (stereognostic functions) are also routinely investigated. Detailed descriptions of the examining methods employed are available in several publications.[3,6]

During the past three years, a major emphasis in the research program in our neuropsychology laboratory has been upon patterns and levels of behavioral-psychological impairment in variously composed groups of epileptic patients. Our approach to studying this complex problem has been to investigate psychological test results in a series of increasingly refined classifications of epileptic patients. The first psychological test comparisons to be presented are between quite broadly defined patient groups (i.e., patients with epilepsy of known versus unknown etiology). In the second study, neuropsychological test comparisons are reported in groups of patients of known and of unknown etiology who are further subdivided into major motor, psychomotor, and mixed seizure disorder classifications. The final study in this series is concerned with an additional variable which is believed to be of importance in evaluating behavioral effects of epilepsy, namely the relationship between different ages at onset of major motor seizures of unknown and known etiology and behavioral deficits as measured by the neuropsychological test battery described above.

The basic question posed in the first study was this: Which is more important in determining behavioral deficits associated with epilepsy, the seizures themselves or the underlying cause of the seizures? Table 1 presents descriptive information on the four groups which were composed in an attempt to provide a preliminary answer to this question.

Group I was composed of subjects without history or clinical evidence of brain damage. Group II was composed of subjects with a diagnosis of brain damage or disease, but without history of epilepsy. Group III was composed of subjects with definite neurological diagnoses of brain damage. Each subject in Group III had unequivocal evidence of epilepsy, presumed to be secondary to specified categories of brain damage. Group III was matched as closely as possible with Group II with respect to type of pathology (Table 2). Group IV was composed of patients matched as closely as possible with members of Group III in regard to type of seizures (Table 3). However, in Group IV, no etiology for the epilepsy could be determined after a thorough study of neurological, neuroradiological, and case history findings.

TABLE 2—*Distribution of Diagnostic Categories*

	Group I	Group II	Group III	Group IV
Closed head injury		22	21	
Chronic brain lesion		11	11	
Cerebrovascular accident		10	11	
Penetrating head injury		4	4	
Arteriovenous malformation		2	2	
Multiple sclerosis		1	1	
Abscess		1	1	

In order to make meaningful test performance comparisons among these four groups, an attempt was made to control for type of pathology between Groups II and III. Inspection of Table 2 shows the close correspondence achieved between these groups on this matching variable.

In addition to matching the groups on age, education, and type of pathology, the distribution of seizure types within Group III (verified brain damage with epilepsy) and in Group IV (epilepsy of unknown etiology) was made as comparable as possible. These comparisons are presented in Table 3.

TABLE 3—*Distribution of Seizure Types*

	Group I	Group II	Group III	Group IV
Major motor seizures			30	29
Major motor seizures and psychomotor seizures			10	10
Psychomotor seizures			9	9
Mixed seizures			2	3

TABLE 4—*Comparison Variables*

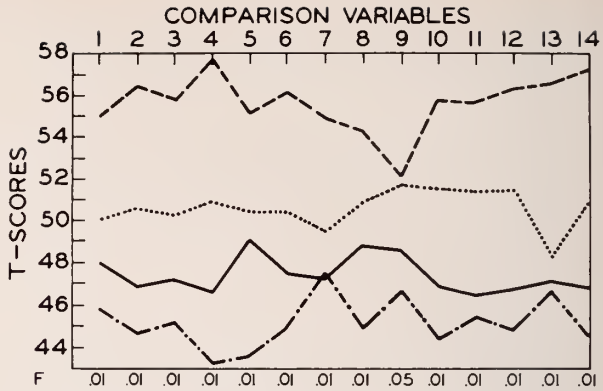
1. Wechsler Adult Intelligence Scale Verbal IQ.
2. Wechsler Adult Intelligence Scale Performance IQ.
3. Wechsler Adult Intelligence Scale Full Scale IQ.
4. Mean time per block on Halstead's Tactual Performance Test.
5. Memory component of Halstead's Tactual Performance Test.
6. Location component of Halstead's Tactual Performance Test.
7. Seashore Rhythm Test.
8. Halstead's Speech Perception Test.
9. Mean finger oscillation speed for dominant hand on Halstead's Finger-tapping Test.
10. Trail Making Test, part A.
11. Trail Making Test, part B.
12. Trail Making Test, part A plus part B.
13. Halstead's Category Test.
14. Halstead's Impairment Index.

The psychological test variables in which the four groups were compared are shown in Table 4.

Variables 1 to 3 are Verbal, Performance, and Full Scale IQ scores from the Wechsler Adult Intelligence Scale.[1] The remaining comparison variables listed in Table 4 are too diversified in nature to be succinctly described. Most of them are from Halstead's Neuropsychological Test Battery[3] and can be viewed as measures of cognitive and adaptive abilities, including concept formation ability, complex psychomotor problem solving, attention, and verbal-symbolic functions.

The T-score means and probability levels associated with mean intergroup differences on the psychological test variables are shown in Figure 1. The numbers along the horizontal axis of the table refer to the psychological test measures as listed in Table 4.

Inspection of the results plotted in Figure 1 indicates that the control group achieved significantly better test scores than the three experimental groups. Mean test performance for the group with epilepsy of unknown etiology exceeded the scores found in the two groups with known brain pathology, one of which group had epilepsy while the other did not. The results of this first study support a conclusion that the presence of epileptic seizures is associated with significantly lower psychometric and adaptive ability levels than those found in control subjects.



F	.01	.01	.01	.01	.01	.01	.01	.01	.05	.01	.01	.01	.01	.01
1-2	.001	.001	.001	.001	.001	.001	.001	.001	.01	.001	.001	.001	.001	.001
1-3	.001	.001	.001	.001	.001	.001	.001	.01	.05	.001	.001	.001	.001	.001
1-4	.05	.01	.01	.001	.01	.001	.01	N.S.	N.S.	.01	.05	.01	.001	.001
2-3	N.S.	N.S.	N.S.	N.S.	.01	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
2-4	.05	.01	.05	.001	.001	.01	N.S.	.01	.05	.001	.01	.01	N.S.	.001
3-4	N.S.	.05	N.S.	.05	N.S.	N.S.	N.S.	N.S.	N.S.	.01	.01	.01	N.S.	.05

---- GROUP 1: CONTROL
—·— GROUP 2: VERIFIED BRAIN DAMAGE WITHOUT EPILEPSY
—— GROUP 3: VERIFIED BRAIN DAMAGE WITH EPILEPSY
····· GROUP 4: EPILEPSY OF UNKNOWN ETIOLOGY

Figure 1

These test-score differences occurred both in epileptic subjects with verified cerebral pathology and in subjects whose epilepsy was of unknown etiology and in whom physical neurological status was judged to be within normal limits. A comparison of the two groups matched for type of pathology, one of which had seizures while the other did not, failed to show additional significant impairment in the seizure group, although both groups performed at levels consistently inferior to the group with epilepsy of unknown etiology. Thus, the results of the first study in this series suggest that epileptic manifestations, whether or not associated with identifiable etiology, resulted in significant impairment of psychological abilities in comparison to control subjects. However, the findings also indicate that in those patients in

TABLE 5—*Descriptive Variables*

	N	Sex	x̄ Age	S.D.	x̄ Ed.	S.D.
CONTROL:						
1. Nonneurological	51	M 31 F 20	33.49	10.09	11.53	2.74
2. Verified brain damage without epilepsy	48	M 35 F 13	33.31	12.01	11.06	2.76
KNOWN ETIOLOGY:						
3. Major motor seizures	23	M 20 F 3	32.43	10.81	10.30	2.57
4. Psychomotor seizures	22	M 12 F 10	29.00	9.60	10.82	2.54
5. Mixed (major motor and psychomotor) seizures	20	M 16 F 4	30.10	8.69	10.80	2.17
UNKNOWN ETIOLOGY:						
6. Major motor seizures	29	M 15 F 14	30.69	10.93	11.31	2.98
7. Psychomotor seizures	22	M 17 F 5	28.27	8.50	11.82	2.67
8. Mixed (major motor and psychomotor) seizures	18	M 10 F 8	26.94	9.12	10.11	2.70

TABLE 6—*Diagnostic Classifications*

Diagnosis	Groups							
	I	II	III	IV	V	VI	VII	VIII
Closed head injury		22	7	9	9			
Chronic brain lesion		12	6	6	6			
Infiltrating tumor		6	4	6	3			
Penetrating head injury		4	1		1			
Arteriovenous malformation		2	3	1	1			
Multiple sclerosis		1	1					
Abscess		1	1					
Total	51	48	23	22	20	29	22	18

whom verified lesions were present, the ictal episodes *per se* did not result in significant additional cognitive impairment when such patients were compared to nonepileptic patients matched for age, education, and type of pathology.

Major interpretative restrictions must be placed upon the results obtained from this first study because a number of factors which are known to bear relationship to psychological test performance were not controlled. Such variables include type of pathology, age at onset of seizures, seizure frequency, and seizure type.

In our second study in this series, the objective was to take a closer look at one of the uncontrolled variables in the study which was just presented. We chose to investigate the relationship between seizure types within categories of known and unknown etiology. Table 5 presents descriptive variables for the groups included in the second investigation.

The three major categories of patients shown in Table 5 include: (1) a control category of nonneurological patients, and a control category of patients with verified brain damage but without seizures; (2) a category of patients with seizures of known etiology, and (3) a category of patients with seizures of unknown etiology. Within the two seizure categories, a further breakdown according to major motor seizures, psychomotor seizures, and mixed (major motor and psychomotor) seizures was accomplished.

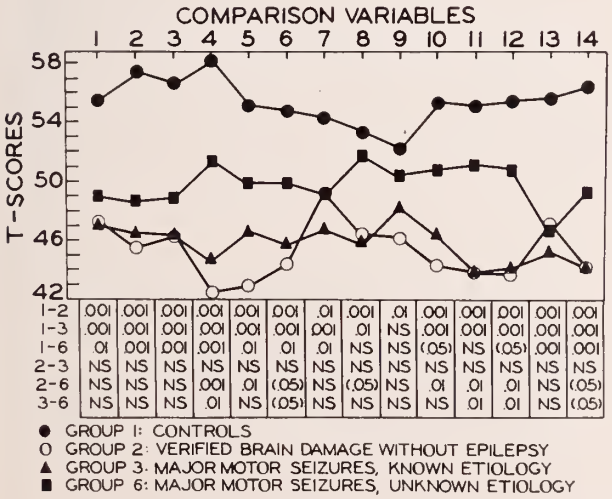


Figure 2

Again, it was necessary to control as closely as possible for type of pathology, and Table 6 demonstrates the rather close matches which were obtained for the brain-damaged group without epilepsy (Group II) and the three groups (III, IV, V) with major motor, psychomotor, or mixed seizures associated with a known neurological diagnosis.

The comparison variables employed were the same as those used in the first study (Table 4). The psychological test-score differences between the two control groups and the groups with major motor seizures of known etiology and of unknown etiology are presented in Figure 2.

Both groups with major motor seizures are clearly inferior to the normal control subjects, as was the group with definite neurological diagnosis, but without epilepsy. Inspection of the mean T scores for groups III and VI in Figure 2 shows that on each comparison variable, the group with major motor seizures of unknown etiology achieved better test performances than the group with major motor seizures of known etiology.

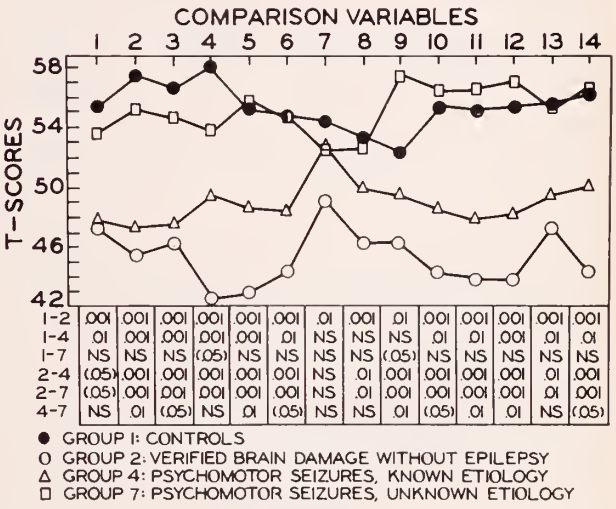


Figure 3

Figure 3 presents similar comparisons for the psychomotor groups of known and unknown etiology.

It is of particular interest to note that the control group and the psychomotor seizure group with unknown etiology (Groups I and VII) performed at almost exactly the same levels on the test battery. The psychomotor group with known etiology performed better than the brain-damaged group without epilepsy, but was inferior to the psychomotor group of unknown etiology.

Figure 4 facilitates inspection and comparison of the results found between groups that were presented separately in Figures 2 and 3.

Figure 4 shows that the two most divergent groups are represented by the psychomotor seizures of unknown etiology which obtained the highest test scores and by the group with major motor seizures of known etiology which performed most poorly on

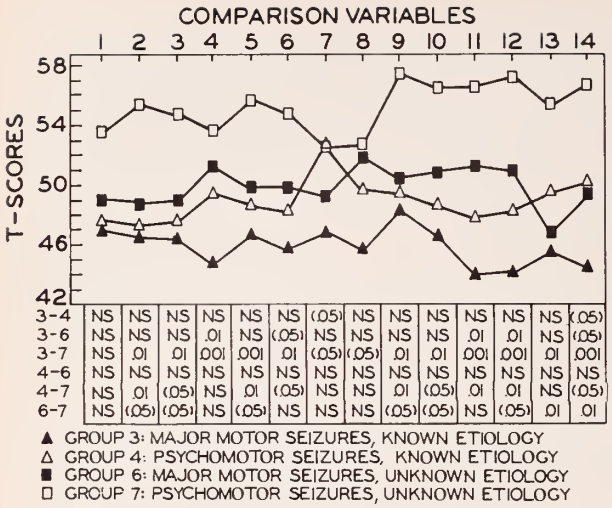


Figure 4

the test battery. Groups IV and VI (the psychomotor seizures of known etiology and the major motor seizures of unknown etiology) performed at almost identical levels, with none of the intergroup comparisons significant at the .05 level of confidence.

Table 7 summarizes the results of the second study by presenting the ranking of the eight groups from best to worst performance, with the rankings based upon the mean impairment index score of each group. The impairment index, which represents the best single estimate of overall performance on the test battery, was computed for each subject by scoring the number of Halstead variables on which the subject's score fell within the range that had been found in previous research[3,4,7] to be characteristic of brain-damaged as opposed to control subjects.

The nonneurological control subjects demonstrated the lowest (i.e., best) impairment index, and this group was significantly better on this composite estimate of test-battery performance than all groups other than the group with psychomotor seizures of unknown etiology. The poorest ranking in the eight groups was represented by the patients with major motor seizures of known etiology.

The third study in the series is concerned with the effect upon psychological test performance of age at onset of major motor seizures of known and of unknown etiology. The test performances of six epilepsy groups composed according to different ages at onset of seizures were compared among themselves and with the performances of three groups of brain damaged patients without epilepsy who were matched with the epileptic patients for age at onset of neurological symptoms or complaints. Table 8 presents descriptive characteristics of these nine groups.

Table 8 presents age, sex, and education information on three groups with major motor seizures of unknown etiology, three groups with major motor seizures of known etiology, and three groups of brain-damaged patients without epilepsy, with one group in each of these major categories having onset age between 0 and 5 years, one with onset age between 6 and 16 years, and one with onset age between 17 and 50 years.

Table 9 summarizes the relationships found between age of onset and the test performance in these three major classifications of patients.

Table 9 shows that within each of the three major groups (major motor seizures of unknown etiology, major motor seizures of known etiology, and brain damage without epilepsy), the best performances were associated with the group with the latest onset (i.e., 17 to 50 years). These best scores are indicated by the asterisk in each major category. The rankings presented on the right side of Table 9

Table 7—*Impairment Index Rankings for Eight Groups*

	Groups	Mean Impairment Index
BEST	I. Nonneurological	3.22
	VII. Psychomotor seizures of unknown etiology	3.45
	IV. Psychomotor seizures of known etiology	5.45
	VIII. Mixed (major motor and psychomotor) seizures of unknown etiology	5.78
	VI. Major motor seizures of unknown etiology	5.83
	V. Mixed (major motor and psychomotor) seizures of known etiology	6.30
	II. Verified brain damage without epilepsy	7.19
WORST	III. Major motor seizures of known etiology	7.48

Table 7 *(continued)—Levels of Significance on Intergroup Comparisons*

Groups	p<	Groups	p<	Groups	p<	Groups	p<	Groups	p<
1-2	.001	1-8	.01	2-8	(.05)	4-5	NS	5-8	NS
1-3	.001	2-3	NS	3-4	(.05)	4-6	NS	6-7	.01
1-4	.01	2-4	.001	3-5	NS	4-7	(.05)	6-8	NS
1-5	.001	2-5	NS	3-6	(.05)	4-8	NS	7-8	(.05)
1-6	.001	2-6	(.05)	3-7	.001	5-6	NS		
1-7	NS	2-7	.001	3-8	(.05)	5-7	.01		

Table 8—*Descriptive Characteristics of Nine Groups*

Group	Description	N	M	F	x̄ C.A.	x̄ Education
I	Major motor, unknown; onset 0-5	16	11	5	26.00	8.94
II	Major motor, unknown; onset 6-16	16	8	8	22.38	10.75
III	Major motor, unknown; onset 17-50	16	8	8	21.19	11.50
IV	Major motor, known; onset 0-5	16	10	6	27.06	9.06
V	Major motor, known; onset 6-16	16	11	5	23.88	10.00
VI	Major motor, known; onset 17-50	16	14	2	22.88	11.69
VII	OBD, no epilepsy; onset 0-5	16	14	2	29.00	10.50
VIII	OBD, no epilepsy; onset 6-16	16	13	3	30.06	10.88
IX	OBD, no epilepsy; onset 17-50	16	11	5	27.38	12.50
		144	100	44		

TABLE 9—*Mean Rank Orders of Nine Groups by Etiology and Onset Age*

Group	Description	(11 Tests) $\bar{x}$	(Impairment Index) $\bar{x}$	Groups	(11 Tests) $\bar{x}$	(Impairment Index) $\bar{x}$
I	Major motor, unknown; onset 0–5	7.64	.74	I, II, III	6.55	.70
II	Major motor, unknown; onset 6–16	8.27	.76	IV, V, VI	4.97	.61
III	Major motor, unknown; onset 17–50	3.73*	.60*	VII, VIII, IX	3.49*	.55*
IV	Major motor, known; onset 0–5	7.18	.69	I, IV, VII	6.15	.66
V	Major motor, known; onset 6–16	6.18	.66	II, V, VIII	6.18	.67
VI	Major motor, known; onset 17–50	1.55*	.48*	III, VI, IX	2.67*	.54*
VII	OBD, no epilepsy; onset 0–5	3.64	.54			
VIII	OBD, no epilepsy; onset 6–16	4.09	.59			
IX	OBD, no epilepsy; onset 17–50	2.73*	.53*			

*Best performance.

represent the rank-order scores for the major combinations of groups. The comparisons shown in the upper right quadrant of Table 9, for example, show that the brain-damaged groups without epilepsy (VII, VIII, IX) had the best performance level with all age-at-onset subgroups included in the analysis. The comparisons shown in the lower right quadrant of the same table present mean rank orders for the groups classified according to age of onset. Again, the test subjects with latest age of onset (Groups III, VI, IX) demonstrated the best performance levels while less satisfactory performances were associated with the two groups with onset of epilepsy or neurological impairment or disease earlier in life. A number of significant interaction effects between etiology and age at onset remain to be analyzed, but even in their present preliminary form, the results of this third study suggest a number of provocative leads regarding the significance of age at onset of epilepsy as a predictive variable for determining later level of neuropsychological impairment or deficit.

The vocational or rehabilitation significance of these three studies has not yet been subjected to empirical investigation. However, we believe that many of the differential patterns and level of neuropsychological impairment which have been shown to be related to various clinical seizure classifications and to etiological and age-at-onset variables may be of considerable relevance to vocational-social assessment and planning for patients with epilepsy. Other studies from the Neuropsychology Laboratory, some of which have been completed and some of which are still in process, are concerned with topics such as: the personality and affective status of various classifications of epileptic patients, and the differential effect of variables such as seizure frequency, duration, and medication histories upon neuropsychological function in these subjects.

Summary

Results of three studies investigating neuropsychological test performances in selected classifications of epileptic patients support the following general conclusions:

Known organic etiology of epilepsy is of more significance for later impairment of neuropsychological functioning than are the seizure manifestations themselves, although patients with epilepsy of unknown etiology demonstrate psychological deficits which are not found in nonepileptic control subjects.

Major motor seizures have a more impairing effect upon psychological abilities than do psychomotor seizures, and these relative impairment levels persist whether major motor or psychomotor epilepsy is of known or of unknown etiology.

The earlier the age of onset of epilepsy in the individual patient's developmental history, the more severe the subsequent behavioral deficits appear to be.

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FROM THE LITERATURE

LIVER CIRRHOSIS association with diabetes, once rare, has increased in this country and Europe from less than 2 per cent to more than 20 per cent in the past several decades. When cirrhosis is present, most likely causes of diabetes are: disturbance of liver's blood glucose regulation or increased inactivation of insulin in the liver by insulin antibodies. Other explanations include: simultaneous occurrence of pancreatic or liver cirrhosis.—Dieter Muting, et al., *Geriatrics,* January, 1969. □

THERAPEUTIC DILEMMAS

COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They are published in a selective manner monthly, except January.

Editor: HARRY BECKMAN, MD, Houghton Fellow in Clinical Research and Consulting Physician, Columbia Hospital

No. 23 of a Series

SUBACUTE THYROIDITIS

Moderator: DANIEL G. SANTER, MD

Participants: HEINRICH ISING, MD
GUENTHER POHLMANN, MD
GHOLI G. DARIEN, MD
NORMAN H. ENGBRING, MD
ROBERT L. ARENDS, MD

Dr. Daniel G. Santer: Having devoted one of our fairly recent Grand Rounds to the discussion of the *Hashimoto* type of thyroiditis, we are supplementing that experience by taking under consideration this morning another frequently encountered form of this disease, *subacute* thyroiditis. In this instance we have the good fortune to have with us Dr. Norman H. Engbring, Associate Professor of Medicine at Marquette School of Medicine and Director of the Metabolic Section of the Department of Medicine at the County General Hospital, who has kindly come in to discuss the subject. The case will be presented by Doctor Ising.

Dr. Heinrich Ising (Resident in Medicine): The patient, a 30-year-old housewife of Italian extraction, was admitted with the chief complaints of headache, sore throat, tender "neck," and fever of one week's duration. Physical examination revealed a tired, feverish patient in moderate pain. The conjunctivae were somewhat pale and the tonsils and posterior pharynx were diffusely injected. The thyroid was enlarged and diffusely tender to touch and on swallowing. The tonsillar glands were enlarged and painful, and there was painful restriction of both flexion and extension of the cervical spine. Her blood pressure was 140/90 mm Hg.

There was history of seven pregnancies and four abortions, and of anemia with each of the pregnancies and frequent vaginal bleeding.

The laboratory findings in significant areas were erythrocytes 5,400,000 (slight hypochromia, aniso- and poikilocytosis); hemoglobin, 10.7 gm/100 ml; hematocrit reading, 30%; reticulocyte count 1.1; serum iron 5 μg (normal: 65–160); serum iron-binding capacity 225 μg (normal: 150–300); iron saturation, <5% (normal: 15–50); serum haptoglobin 39.3 μg (normal: 56–108); white blood cell count, 11,400; sedimentation rate, 89; electrolytes, liver function panel, and blood urea nitrogen were within normal limits; there was a slight increase in serum globulin and decrease in albumin on electrophoresis. The T-3 was slightly increased and T-4 suggested exogenous iodine intake. The chest x-ray film was interpreted as normal. Urinalysis was normal and the stool was negative for occult blood. Beta-hemolytic streptococci were recovered from mucopurulent sputum; the antistreptolysin-0 titer was 1250 Todd units.

The patient was given penicillin, iron, desiccated thyroid, aspirin and prednisone orally and improved rapidly. On the third hospital day she was afebrile, the thyroid gland was smaller and much less tender, the white blood cell count was 7,200, and the sedimentation rate was declining. There was still slight pain on motion of the cervical spine. She was discharged taking thyroid and prednisone medication on the sixth hospital day.

Dr. Santer: Are there any questions regarding the account of the case?

A Physician: Why was the T-4 elevation attributable to exogenous iodine?

Dr. Robert L. Arends (Department of Laboratory Medicine): We use a column chromatographic procedure for determination of thyroxin. The thyroxin is adsorbed on an ion-exchange resin which is then washed with buffers to remove most of the interfering iodine compounds. Thyroxin is eluted from the column with acetic acid and we expect about 80% of it to appear in the first of two elution fractions. If, for example, we find an equal amount of iodine in each of the two fractions, we think this suggests the presence of an organic iodine compound other than thyroxin—and we comment in our report that exogenous iodine appears to be present.

Dr. Engbring: The presence of exogenous iodides is of course a vexing problem. At the County General Hospital we have turned to the Murphy–Pattee method for determining thyroxin, with which we believe we are now getting valid tests for blood thyroxin even if the patient has been given gallbladder dye the night before.

Dr. Santer: If there are no further questions at this point I will call upon Doctor Pohlmann. Do you have a contribution from your laboratory?

Dr. Guenther Pohlmann (Department of Laboratory Medicine): Yes, we did an I^{131} thyroid scan on this lady. An uptake study was not requested, but the information from the scan itself (Fig 1) indicated a low uptake, perhaps in the range of 2% to 3%. A reduced uptake of this sort indicates the possibility of subacute thyroiditis, or the suppression of thyroid function by administered desiccated thyroid, or from exogenous iodine ingestion or administration. The gland appeared in the scan to be slightly enlarged, particularly in the right lobe; there was still some activity in the right lobe but very little in the left lobe.

Classically in subacute thyroiditis the I^{131} uptake is depressed, and because of this the gland does not visualize well on the scan. This gland does not respond well to thyroid-stimulating hormone (TSH), and therefore the TSH stimulation test is sometimes of additional assistance in establishing the diagnosis. Sometimes, also, the I^{131} conversion ratio (a measure of the conversion of iodine into the protein-bound phase) is relatively high in comparison with the uptake—which gives us a third parameter of thyroid function that may be helpfully studied in these cases. It should be noted, however, that in acute bacterial thyroiditis, which is a rather rare entity, thyroid uptake is practically always normal or nearly so, in contradistinction to the depression in the uptake seen in the subacute cases such as we are considering today.

Dr. Santer: At this point we will call on Doctor Darien for whatever he may add of clinical interest regarding the present patient.

Dr. Gholi G. Darien: I have really very little to add. The patient was admitted here on January 13, but I first saw her for a complete physical examination in mid-June of the preceding year. At that time she had a hemoglobin of 11.4 gm/100 ml and hematocrit reading of 36%. Her complaint was of chronic headache, of which she said her husband and son, but not her daughter, also complained. I was able to learn that there is a great deal of noise and tension in the home, which could possibly account for that family ailment. She was otherwise asymptomatic, but, because of the anemia and the Italian extraction, we studied her carefully for hemoglobinopathy, but with only negative results. The husband and daughter (the children are 14 and 13 years old, respectively, so the patient, who is now only 30 years old, must have married very early) are not anemic, but the son is. The patient's anemia, however, is a purely iron-deficiency one.

Dr. Pohlmann: Here in the hospital we have found the red cells microcytic but normochromic. Were fragility studies done in the summer?

Figure 1

Dr. Darien: They were not done at that time because we had electrophoresis studies underway. Before the introduction of electrophoresis, the determination of red cell fragility was an important facet of the examination for thalassemia. These patients would be found to have microcytic anemia with decreased red cell fragility and normal iron studies. This lady has, in fact, an extremely low iron saturation, less than 5%. The reticulocyte count is practically normal. Unfortunately our electrophoresis studies in the summer failed to be contributory because of an inadvertent technical error. We checked the liver panel and found it to be normal, and there was no elevation of serum bilirubin.

Dr. Engbring: Did the patient have any thyroid enlargement when you examined her in the summer?

Dr. Darien: None whatever, and appeared to be completely euthyroid. Then, six months after the examination in the summer, she came to my office with the complaints that Doctor Ising has described, for which she was admitted a few days later. The thyroid was the most tender that I have ever seen and she was extremely ill, the thyroiditis apparently being compounded by a streptococcal sore throat. The response to therapy was very rapid and complete, however, and she is now about two weeks out of the hospital and asymptomatic. Her present prednisone dosage is 10 mg daily, which will be tapered off as rapidly as seems feasible. I shall be much interested to hear what Doctor Engbring will have to say regarding subsequent therapy.

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Dr. Santer: Thank you, Doctor Darien. Doctor Engbring will now elaborate upon the subject of subacute thyroiditis.

Dr. Norman H. Engbring: In approaching such a patient as we have under consideration today the problem is primarily one of differential diagnosis with regard to the painful, tender thyroid gland. A fairly frequent occurrence is hemorrhage into a preexisting thyroid nodule or colloid cyst. Often this patient will have been aware of some prior enlargement of the gland, but occasionally these nodules may be so small as to be undetected until there is sudden onset of pain. Hemorrhage of this sort can be ruled out in the present patient, I think, both because we know that there was no previous thyroid enlargement, and the pain and tenderness were diffuse rather than localized.

Another entity to be considered is acute bacterial thyroiditis, which is of rather rare occurrence. In this malady the signs of bacterial inflammation are present as in the case of an abscess or cellulitis anywhere else in the body; the skin overlying the gland is red and hot and the process is a localized one in most instances rather than one involving the entire gland. Another suppurative process may affect a thyroglossal cyst, which, if low down over the isthmus, might be confused with suppurative thyroiditis.

In our present case there is nothing pointing to a suppurative process of this sort, although admittedly the patient did have an associated streptococcal infection when she entered the hospital.

Chronic thyroiditis, specifically Hashimoto's type, is fairly common, but that malady is characterized by an enlarging gland, and when there is pain or tenderness, which is unusual, it is relatively mild.

Another entity to be ruled out is carcinoma of the thyroid, since there may be pain with a rapidly growing malignancy, but the gland is nodular rather than diffuse. The rare chronic thyroiditis, which includes a fibrous process involving the thyroid, Riedel's struma, hardly comes under differential consideration here.

Thus we are left in the present instance with the entity known generally as subacute thyroiditis, although it also is described in the literature as acute nonsuppurative, giant-cell, DeQuervain's, granulomatous and pseudotuberculous thyroiditis. We believe this to be the malady with which this morning's patient is afflicted.

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In seeking to establish the diagnosis of subacute thyroiditis, there are several very helpful signs to follow. In the first place, the patients are usually middle-aged women, although the malady can occur at any age and is occasionally seen in men. In the second place, the entire thyroid gland is symmetrically enlarged and tender in most instances; to be sure, in some cases in the beginning the process will involve one lobe or sometimes just the isthmus, but it then usually becomes diffuse, often within a matter of days. In fact, there is evidence, from scanning and from uptake studies, that the process involves the entire thyroid from the beginning although only one lobe may appear to be affected at the onset. These glands are tender—diffusely and exquisitely so—but the other signs of inflammation are usually lacking—there is generally no redness of the skin and no edema overlying the area as there would be with a suppurative process, and the white blood cell count is normal.

Very often, radiation of pain into the area up behind the ear, uni- or bilaterally, points toward the diagnosis. These people may have so much pain and tenderness when they turn the head that they splint and develop a severe torticollis, which may indeed mask the underlying thyroiditis. This was a very prominent symptom in our present case.

Very often there has been an upper respiratory infection preceding the onset of the attack, and this was also true in our case. The course that the illness takes is not particularly helpful in determining what we are dealing with because it is very variable. We have seen patients in whom the picture developed fulminantly and promptly recurred during a period of many months each time that therapy was discontinued; in other instances it has resolved in 24 hours with no more than analgesic therapy and has not returned. Such evanescent attacks as the latter lead me to believe that the malady may be much more common than is suspected from the present documented indications of its incidence.

Laboratory studies (aside from thyroid function tests) are not necessarily helpful. The sedimentation rate is usually high, as it was in this patient, and the white blood cell count is usually normal. The serum proteins do not follow a typical pattern; elevation of the alpha-2 globulins is not a consistent finding, but there is often a nonspecific increase in globulin, albumin remaining fairly constant.

The pathologic process affecting the gland causes degeneration of follicular epithelial cells, with the result that thyroglobulin spills out and apparently some enters the blood stream. Proteolysis of intrathyroidal thyroglobulin may release thyroxin and triiodothyronine into the circulation, and the patient frequently becomes mildly hyperthyroid. The increase in metabolic rate that is observed is therefore not merely a reflection of the febrile state but of hyperthyroidism as well. The protein-bound iodine (PBI) is elevated and the T-3 resin uptake frequently also; and if you do a specific T-4 test, you may find that elevated too. This hyperthyroidism is usually not of a severe type, and in fact the patient often remains euthyroid.

As was previously pointed out, the radioiodine uptake is typically low, but it is not clear why this is so. We do know that the inflammatory process is causing destruction of cells that presumably would be trapping iodine, and perhaps this is a sufficient explanation. However, Doctor Pohlmann mentioned that there is frequently an increased conversion ratio —which means that iodine must have been trapped by the cells, converted into thyroid hormone, and released back into the circulation. If this is happening the problem cannot therefore be one of a mere decrease in iodine trapping, for there also appears to be a rapid release of formed thyroid hormone. We do not yet have enough definitive information in this area.

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The relative decrease in response to thyroid-stimulating hormone (TSH) has been mentioned. Whether this means that the gland cannot respond well to an injection of exogenous TSH, or whether we are merely unable to detect its response, I am not sure. We measure TSH response by determining thyroid uptake; but all we are really doing here is measuring the radioactivity that is appreciated by the detector—we do not learn how much radioactive iodine has been picked up and released into the circulation as thyroid hormone. In short, we determine only net uptake and do not derive any data that tell us how rapidly that gland is functioning. We need more information in this area also.

Thyroid antibodies may sometimes be found in low titer in subacute thyroiditis, although this is appar-

ently not an autoimmune disorder. It is not surprising that they should be formed since colloid is being spilled outside the follicles; and when it is outside the follicles, it acts as a foreign protein which is ingested by foreign body giant cells and should incite an autoimmune reaction.

There is little exact knowledge of the etiology of subacute thyroiditis, although the inference that it is of viral origin is strong since it has occurred at times in epidemic form in association with ECHO, coxsackie, adenovirus, and particularly mumps virus. Certainly the account of recent upper respiratory infection is prominent in the history of many cases. There also appears to be some association between the disease and thyrotoxicosis (Grave's disease), but the suggestively high incidence of the latter malady either preceding or following the thyroiditis may be no more than coincidence.

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Regarding therapy, if the problem is mild, salicylates usually are sufficient. If, after an adequate trial of salicylates, relief is not satisfactory, then steroids are indicated. Steroids do not alter the course of the disease in any way so far as we know. They do not cause the process to regress. But they do give rapid symptomatic relief and they must reduce the inflammation because the goiter recedes in size and is no longer tender within 24 to 48 hours. However, if the dose is reduced below that level which is necessary to suppress the inflammatory reaction, the symptoms will recur. So what is usually done in treating these patients is gradual decrease in dosage over a period of days, and if the patient's symptoms recur, increase the dose slightly and maintain it for another couple of weeks before again reducing the dose. The process will eventually subside, and the patient will remain asymptomatic. Steroids usually can be used in relatively low doses, and because it is a limited disorder, the problems of long-term steroid therapy should not occur.

Dr. Santer: Thank you Doctor Engbring. Are there questions?

A Physician: Is there a place for radiation therapy in subacute thyroiditis?

Dr. Engbring: Not any longer since the advent of the corticosteroids, although it was formerly used. The results were equivocal. I think the current consensus is that if corticosteroid therapy fails to induce symptomatic remission, the diagnosis had better be reviewed.

A Physician: What form of thyroid therapy do you recommend in these patients?

Dr. Engbring: Unless the patient is hypothyroid, and most of them are not, I do not use thyroid therapy. This is of course in direct contradistinction to the state of affairs in Hashimoto's thyroiditis, in which full thyroid hormone replacement is the practically specific remedial therapy.

A Physician: I am rather surprised by your statement that hypothyroidism does not occur often in these cases because it seems to me that I have seen it rather often following the hyperthyroid phase of the disease.

Dr. Engbring: That has not been the general experience; following Hashimoto's thyroiditis it is common, but not following subacute thyroiditis.

A Physician: In the case that smolders along with recurrent episodes, do you treat with corticosteroids each time there is a recurrence, or do you resort to thyroid here?

Dr. Engbring: You will simply have to review your diagnosis carefully. If the case is certainly one of subacute thyroiditis, a corticosteroid is the drug; if it is Hashimoto's thyroiditis, use thyroid.

A Physician: When you do resort to thyroid therapy for any purpose, what preparation do you use?

Dr. Engbring: If you have a good potent preparation of desiccated thyroid it is going to be cheaper than any of the other forms and just as good. If, however, you cannot rely on your source, you are better off using one of the synthetics. The U.S.P. does not require that thyroid substance be standardized on the basis of its biological potency but only its iodine content, although some of the pharmaceutical companies do standardize their product biologically. The best policy is just to use the compound of one of these companies consistently and you will always know what to expect. At the County General Hospital, where all drugs are purchased on the basis of competitive bidding, we had great difficulty in standardizing our thyroid dosages until we insisted that desiccated thyroid always come from the same company.

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A Physician: If a pharmacist carries only one company's product but fills your prescription from a rather old supply, does this matter?

Dr. Engbring: No, it does not; desiccated thyroid does not deteriorate on the shelf, unless exposed to moisture.

A Physician: As subacute thyroiditis regresses, are you ever left with nodular tissue that you are puzzled what to do about?

Dr. Engbring: Not as a rule; if the case is truly one of subacute thyroiditis, you may expect the gland to return to normal conformation without any nodules detectable by palpation.

Dr. Santer: Thank you, Doctor Engbring. I think it may be said that we have had a practical and useful type of discussion of the subject of subacute thyroiditis this morning. Perhaps, since we dealt with the Hashimoto type of thyroiditis at an earlier conference, we would do well to arrange a Grand Rounds on thyrotoxicosis for the reasonably near future? □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Associate Professor of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

USE AND ABUSE OF GAMMA GLOBULIN

By E. RICHARD STIEHM, M.D.
Madison, Wisconsin

GAMMA GLOBULIN, known officially as Immune Serum Globulin, (Human) U.S.P. or Poliomyelitis Immune Globulin (Human), is an important and useful drug in the prevention and therapy of certain illnesses. But not unlike antibiotics and vitamins, gamma globulin is used unnecessarily in a wide spectrum of illnesses, with the result that many patients are subjected to unnecessary expense, pain, possible side effects, and denial of alternate more suitable medical management. In this work, a summary of the properties, indications, contraindications, dose, and side effects of gamma globulin will be presented. A more complete review has recently been published.[1]

Physiology

Gamma globulin, comprising about 20% of the serum proteins, contains the antibody activity of serum. Gamma globulin is not a single protein but consists of three main (γG, γM and γA*) and several minor immune globulins, which can be measured and separated by appropriate immunologic and biochemical techniques such as immunoelectrophoresis and radial diffusion in agar. Paper electrophoresis, as used in clinical laboratories, does not delineate the individual gamma globulins, but instead is an approximate measure of the total level of all the immune globulins.

From a clinical standpoint γG-globulin is the most important. It has a molecular weight (MW) of 160,000, makes up 85% of the gamma globulin fraction, has a normal adult serum level of 1158 ± 305† mg/100ml, and contains most of the antibacterial, antitoxic, and antiviral activity of the serum. Commercial gamma globulin is almost totally γG-globulin. Gamma G-globulin has a half life in the circulation of about 20 to 30 days and readily crosses the placenta, imparting passive immunity from the mother to the newborn infant.

Gamma M-globulin, also known as macroglobulin because of a MW of 1,000,000, makes up about 5% of the gamma globulin. The adult serum level of 99 ± 27 mg/100ml. Many antibodies to gram-negative organisms (e.g. typhoid O antibodies), natural antibodies (e.g. Anti A- and Anti B-isoagglutinins, Forsmann agglutinins) and autoantibodies (e.g. rheumatoid factor) are γM-globulins. The half life of γM-globulin is 7 to 9 days, γM-globulin does not cross the placenta.

Gamma A-globulin, comprising 10% of the gamma globulin fraction, has an adult serum concentration of 200 ± 61 mg/100ml. While many antibodies have been found in γA-globulin, no unique antibodies are known, and complete absence of this immune globulin in the serum is not uncommon, and is seemingly without clinical consequences. Thus, the biologic role of serum γA-globulin is unknown. Despite a MW of 160,000, serum γA-globulin does not cross the placenta.

Secretory γA-globulin (γA_s), the chief immunoglobulin of exocrine gland secretions (breast milk, tears, saliva, gastrointestinal secretions) has a structure similar but not identical to serum γA-globulin.[2] It consists of two or three serum γA-globulin molecules plus an additional ligand termed "transport piece" with a resultant MW of 500,000. Secretory γA-globulin has the function of protecting mucous membranes from local invasion of microbial agents. Secretory γA-globulin is synthesized locally in glandular tissue.

Synthesis

The newborn infant synthesizes all three serum immune globulins poorly (although trace levels of γM-globulin are formed by nearly all newborns)[3] but receives an adult level of γG-globulin transplacentally from the mother. Shortly after birth immune globulin synthesis accelerates, but the maternal

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* Also termed IgG, IgM and IgA Immune Globulins.[1]

† One standard deviation.

TABLE 1—*Levels of Immune Globulins In Sera of Normal Subjects, By Age*[3]

Age	IgG		IgM		IgA		Total Immune Globulin	
	mg 100ml	% of Adult Level	mg 100ml	% of Adult Level	mg 100ml	% of Adult Level	mg 100ml	% of Adult Level
Newborn	1,031 ± 200*	89 ± 17	11 ± 5	11 ± 5	2 ± 3	1 ± 2	1,044 ± 201	67 ± 13
1– 3 mo.	430 ± 119	37 ± 10	30 ± 11	30 ± 11	21 ± 13	11 ± 7	481 ± 127	31 ± 9
4– 6 mo.	427 ± 186	37 ± 16	43 ± 17	43 ± 17	28 ± 18	14 ± 9	498 ± 204	32 ± 13
7–12 mo.	661 ± 219	58 ± 19	54 ± 23	55 ± 23	37 ± 18	19 ± 9	752 ± 242	48 ± 15
13–24 mo.	762 ± 209	66 ± 18	58 ± 23	59 ± 23	50 ± 24	25 ± 12	870 ± 258	56 ± 16
25–36 mo.	892 ± 183	77 ± 16	61 ± 19	62 ± 19	71 ± 37	36 ± 19	1,024 ± 205	65 ± 14
3– 5 yr.	929 ± 228	80 ± 20	56 ± 18	57 ± 18	93 ± 27	47 ± 14	1,078 ± 245	69 ± 17
6– 8 yr.	923 ± 256	80 ± 22	65 ± 25	66 ± 25	124 ± 45	62 ± 23	1,112 ± 293	71 ± 20
9–11 yr.	1,124 ± 235	97 ± 20	79 ± 33	80 ± 33	131 ± 60	66 ± 30	1,334 ± 254	85 ± 17
12–16 yr.	946 ± 124	82 ± 11	59 ± 20	60 ± 20	148 ± 63	74 ± 32	1,153 ± 169	74 ± 12
Adults	1,158 ± 305	100 ± 26	99 ± 27	100 ± 27	200 ± 61	100 ± 31	1,457 ± 353	100 ± 24

Values shown above were derived from measurements made in 296 normal children and 30 adults. Levels were determined by the radial diffusion plate method using specific rabbit antisera to human immunoglobulins.
*One Standard Deviation.

passive gamma globulin is catabolized more rapidly than newborn synthesis, with the result that *all infants are hypogammaglobulinemic by adult standards in the period from age 1 to 6 months.* The failure to appreciate this fact subjects innumerable infants to unnecessary courses of gamma globulin.

Table 1 presents levels of γG-, γM-, γA- and total-gamma globulin determined by radial diffusion in normal subjects at different ages. Inspection of this table should emphasize the necessity of comparison of any gamma globulin determination in a child with appropriate age-matched controls. Commercial radial diffusion plates[4] to measure levels of individual immunoglobulins are available to help the physician evaluate a patient suspected of immunologic deficiency.

Indications and Contraindications

These are summarized in Table 2. Special gamma globulin, prepared from convalescing or recently-immunized individuals, has a known antibody content and is available for mumps, vaccinia, pertussis, tetanus, and measles. Guidelines for their use, as well as an up-to-date discussion of diagnostic procedures, other treatment, quarantine and communicability regulations and recommended immunizations are best summarized in the "Red Book" of the American Academy of Pediatrics.[5]

Gamma globulin is to the immunologically deficient patient what insulin is to the diabetic patient. However, the diagnosis of immunologic deficiency is made much too frequently on insufficient evidence. Patients with immunologic-deficiency diseases such as agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia generally have severe recurrent bacterial infections (pneumonia, meningitis, empyema, osteomyelitis), chronic diarrhea, and debilitation or failure to thrive. They rarely present with asthma, runny nose, or recurrent respiratory infections (Table 2). When a patient is suspected of immunologic deficiency, a paper electrophoresis determination for total gamma globulin level is indicated. If the gamma globulin level is low or borderline, when compared to age-matched controls (Table 1), further studies are indicated before gamma globulin therapy is initiated. These include: (1) quantitative determination of each immune globulin; (2) lymphocyte counts to rule out lymphopenic agammaglobulinemia,* (3) Schick test to measure γG antidiphtheria antibody, and (4) isoagglutinin titers to measure γM anti-A and/or anti-B. No patient should receive repeated gamma globulin injections without such evaluation.

TABLE 2—*Indications and Contraindications for Gamma Globulin*

A. Disorders in which special human gamma globulin of known antibody content is available.

Disorder	Use
1. Measles	Prevention
2. Mumps	Prevention
3. Pertussis	Prevention and Treatment
4. Tetanus	Prevention and Treatment
5. Vaccinia	Prevention and Treatment

B. Disorders in which pooled gamma globulin (Immune Globulin [Human] U.S.P.) is beneficial.

Disorder	Use
1. Immunologic Deficiency Disease	Treatment
2. Severe Burns*	Treatment
3. Severe Refractory Bacterial Infection*	Treatment
4. Chicken Pox	Prevention
5. Infectious Hepatitis	Prevention
6. Poliomyelitis	Prevention
7. Rubella*	Prevention
8. Serum Hepatitis	Prevention

C. Disorders in which gamma globulin has no proven value in prevention or treatment.

1. Asthma, allergic or infectious.
2. Recurrent respiratory infection.
3. Recurrent sore throats, ear infections, or urinary tract infections.
4. Respiratory allergy.
5. Transient hypogammaglobulinemia of infancy.

*Benefit not well established.

Pharmacology, Dosage, Side Effects

Commercially available gamma globulin, found in Cohn Fraction II, is prepared by alcohol fractionation of pooled sera. This procedure concentrates the antibodies, removes the hepatitis virus, and provides a stable product for intramuscular injection. The special gamma globulins are assayed for certain antibodies; the gamma globulin for general use is often assayed for polio antibodies. The latter costs one or three dollars per milliliter to the patient.

* A severe form of agammaglobulinemia in which delayed hypersensitivity is deficient.[1]

Gamma globulin is a viscous solution with a concentration of 165 mg of γG-globulin/ml. It must be given intramuscularly or subcutaneously with an 18 or 20 gauge needle. There is a high risk of anaphylactic reactions if given intravenously. The recommended dose of gamma globulin for immunologic deficiency diseases is 0.6 ml/kg (0.3ml/lb, 100mg/kg) up to a maximum of 20 ml at monthly intervals. A double dose is given at the onset of therapy. If this dose is insufficient, the frequency of injections is increased to biweekly or weekly intervals. Since a gamma globulin injection raises the serum gamma globulin only slightly (50–100mg/100ml),[6] repeat gamma globulin determinations are not a useful guide to therapy. The use of small intradermal injections of gamma globulin is contraindicated.

Toxic reactions following gamma globulin are rare, but pain at the site of injection for several days is common because of the large volume injected. Anaphylactic reactions following intramuscular injection of gamma globulin have been reported,[7] and are probably due to *in vitro* aggregation of the solution. Genetic subgroups of human gamma globulin exist and an immunologically normal individual may form antibodies to a subgroup different from his own.[8] The biologic and therapeutic significance of these anti-gamma globulin antibodies has not been established.

Fresh plasma has been used as an alternative to gamma globulin therapy,[6] with the advantages that it contains all of the immune globulins and can be given intravenously. It has the disadvantage of the risk of hepatitis. There are efforts to modify gamma globulin so it is safe for intravenous use;[9] these preparations are not yet available commercially.

Summary

Single injections of human gamma globulin are indicated in the prevention and treatment of several infectious diseases. Special human gamma globulin preparations are available for measles, mumps, pertussis, tetanus, and vaccinia. Repeated injections of gamma globulin should be reserved for patients with proven immunological deficiency diseases.

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ANOTHER ARTICLE ON EPILEPSY

One of the papers presented at the 128th Annual Meeting of the State Medical Society of Wisconsin, May 15, 1968, in Milwaukee, which was part of the Symposium on Epilepsy, was printed in the April 1969 issue of the *Wisconsin Medical Journal* as the Comments on Treatment feature. Its title was "Medical Therapy of Epilepsy," authored by Dr. Philip T. White of Milwaukee. Doctor White is Professor and Chairman, Department of Neurology, Marquette School of Medicine, Milwaukee. □

SOCIAL CHARACTERISTICS AND PATIENT EXPECTATIONS TOWARD MENTAL HOSPITALIZATION

LAWRENCE S. LINN, PhD, Milwaukee, Wis: **Arch Gen Psychiat** 20:457–469 (Apr) 1969

The purpose of the present study is to define the content and range of expectations which patients express upon entrance to a mental hospital and to examine how such expectations might be related to the social and social-psychological characteristics which patients have.

On the basis of 187 completed interviews with patients upon their admission to a state mental hospital, it was found that the differential orientations patients held toward their hospitalization were meaningfully related to the social situation from which they had come, the way in which their entrance to the hospital had occurred, and certain social characteristics which they possessed. Statistically significant relationships were found between the orientations patients expressed and their psychiatric classification, sex, size of home town, marital status, as well as to the person whom they felt played the most important role in the decision concerning their hospitalization, and to the procedure used in their admittance. Patient orientations were not found to be significantly related to their age, educational background, occupational status, number of previous hospitalizations, the distance traveled to the hospital, or whether they were a first or readmission to the hospital studied.

Doctor Linn is Research Associate, Center for Advanced Study in Organization Science, University of Wisconsin–Milwaukee. □

PRESIDENT'S PAGE

ROBERT E. CALLAN, M. D.

OUR GENERATION GAP

EVEN LABOR LEADERS these days are seriously concerned with the generation gap in many unions where younger workers are approaching a majority and have little knowledge or appreciation of the background and struggles of the U.S. union movement—or could care less. The opening of another medical school year brings to mind our own widening generation gap.

Physicians are conservative by nature, having gained humility through continuous experience in caring for those most complex creatures—other humans. We learn, sometimes the hard way, to avoid snap diagnosis, and with greater maturity to consider carefully the differential diagnoses, and then decide how best to treat the whole patient with the options available in a particular case. Because this conservatism many times carries over into economic and political fields, physicians and their organizations are frequently and often unjustly criticized with dragging their feet on the great and complicated social problems of our day. Most physicians have disciplined, yet open, minds and are dedicated to the highest ideals of their profession. They feel that the socio-economic problems of medicine should be given the same thoughtful and objective consideration that is characteristic of medical research, where truth and facts outweigh opinion and emotion, so that the solutions derived might provide all of our citizens with high-quality and humane medical care at reasonable cost.

In these days of frenetic activity in health planning, it must be realized that proper preparation now is time well spent. Samuel Johnson aptly puts it: "In all evils which admit a remedy, impatience should be avoided, because it wastes that time and attention in complaints which, if properly applied, might remove the cause."

Wisconsin has always been a leader in social progress; and since its inception in 1841, the State Medical Society of Wisconsin has had as its prime objective the task of making the medical profession more useful to the public in prevention and cure of disease and in prolonging and adding comfort to life. Wisconsin medicine has always been and must continue to be progressive and responsive to our citizens' health needs.

We need the spirit, the enthusiasm, and the idealism of our medical students to renew us in our continuing efforts. These young men and women are tomorrow's medical leaders; and in the best interests of all of our people, they must be properly prepared for the tasks. In the past, representatives of medical student organizations have been invited to our annual House of Delegates meetings, where the policies of our society are set. All medical students are invited to the annual meeting's scientific sessions.

These contacts are not sufficient. Students should be invited to our county and state societies' scientific and social programs, and their leaders to the many committee meetings at all levels dealing with organizational matters.

With a much closer relationship between medical student, physician, and professional organization, a much better understanding of our common goals and objectives could develop, and hopefully, the generation gap in medicine would disappear.

Robert E. Callan M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Medical Activists

UNPLEASANT AS IT may have been, the recent nasty attempt on the part of young doctors to provoke a confrontation at the annual meeting of the AMA House of Delegates may have had a long term salutary result. The result may not be the one that the radicals were looking for, but it could be one that will take the game away from them and ultimately produce a lasting benefit for the entire medical profession.

Soon after the disruptive episode, the House of Delegates was addressed by Edward Martin, president of the Student American Medical Association. His talk was moderate, restrained, literate, honest. Yet underlying his sentiments were precisely the concerns that were exercising the radicals; his view of the shortcomings of the medical profession with regard to purpose and attitude are no less realistic than that of those who sought a violent confrontation with the officials of the AMA.

The chief difference between Mr. Martin and his bearded contemporaries is that he and his group are doing something about what they find wrong in their chosen profession. They are not simply making a spectacle of themselves; they are not simply alienating people who may, at the moment, not agree with them; they use reason and analysis as instruments of persuasion rather than dirty names and hostility-evoking contempt.

Because he represents the large, reasonable sector of young doctors, Mr. Martin and the spokesmen of the SAMA should be listened to with respect. A good place to start is with the remarks he made at the New York convention.

He pointed out that the reaction to the rude, coarse antics of the disheveled revolutionaries was just as frightening as the behavior of those who unwittingly tried to force a confrontation in the presence of the press. He said, "I guess the most horrible moment for me was a delegate who ran to the stage and yelled, 'Let's kill the bastards' and looked like (sic) he really meant it."

Mr. Martin continued that the application of simple, generalizing answers does not confront the problem nor do they permit any understanding of what the medical student activist is concerned with. Name calling obscures the issues and makes it easy to evade responsibility for controlling the changes that are inevitably on the way.

Most of the activists are good students, he noted, often from the best universities. They have been in local community health projects, in efforts to reform medical education and in the active discussions of medical ethics and practice. "Most of these students," he said, "are the leaders in their schools. The radicals are barely heard." Barely heard, that is, until they find an opportunity to force a confrontation with the medical establishment and expose what they characterize as the retarded sense of social change, the intransigent attitude toward progress in the field of delivery of health care, and the reactionary posture of the fat-

cat doctor who trembles at the thought that his substantial income may somehow be diminished.

While Mr. Martin and other thoughtful health professionals deplore the violent, childish confrontation the radicals tried to bring about at the convention, they are not indifferent to what the revolutionaries are trying to say. Behind those hirsute lips and under those untrimmed coiffures there are ideas worthy of serious consideration. Is the AMA really the "American Murderers' Association?" Is that how we seem to the poor, the oppressed and disfranchised? Do they have good reason for thinking of us in that way? Are we facing up to our responsibility to extend the benefits of modern medicine to all segments of our society? Are we putting a price tag on the miracles of modern medicine which makes it available only to the affluent?

Are the doctors who discuss the problems of handling "darkies" in their practice facing the realities of the 1960–70 decade? Are the members of the American Association of Physicians and Surgeons, who only yesterday posted signs in their waiting rooms announcing that they would never cooperate with Medicare, really practicing in this day and age? Are the doctors who are firmly convinced that nobody has a "right" to medical care from them unless they have the money to pay for their services alive to the ferment in the United States today?

Mr. Martin and the SAMA believe that the medical profession is capable of rising to the challenge of its own smugness and its retarded sense of social responsibility. But before it can take action, it must be aroused. If they did anything, therefore, the radicals who caused the uproar at the New York convention prepared the way, so to speak, for the temperate activists among our young doctors and serious medical students. They seem to be alert to the problems and, happily, they appear to have some solutions worth trying.

The medical profession and in particular the leaders of organized medicine should pay close attention to what the young activists are saying. If the answers they advance are unworkable, they at least form a starting point for the development of workable solutions.

Their concern for modifications in the delivery of health care reflects a general concern among all sections of the population. Some doctors have already undertaken experiments in alternate methods of caring for the sick and injured on a basis economically acceptable to them. More must be done, and the leadership of organized medicine can no longer drag its feet or characterize the efforts to find solutions as a "communist plot."

It is no longer possible for a doctor to practice medicine as though his patients lived in an economic and social vacuum. He must be involved in the same society in which the patients live, and he must take up the responsibilities that the requirements of his practice impose upon him. As Edward Martin suggested, unless we assume the leadership in a dynamic and creative manner, others will. And American medicine has seen the bearded faces and the open-toed sandals of those who would dearly love to assume that leadership.

Dr. Dwight Wilbur, in his address to the House of Delegates, urged doctors to develop a heightened social sense to challenge traditions and complacency. Doctors everywhere can start sharpening their awareness by listening first of all to those who alienate them, but most of all to the young doctors in our midst who see our problems with eyes unscaled by vested interest. They stand closer to the wellsprings of social change than do those of us who entered medical practice in another age.

—D.N.G. □

Information and Referral Services Tell People With Problems Where to Turn for Help

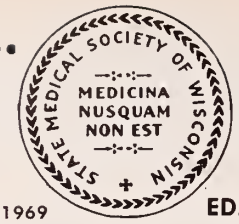
As cold and remote as the urban community may seem today, it can offer help for sudden or chronic problems—if there is a properly organized Information and Referral Service to guide people to the help they need.

TELL ME WHERE TO TURN is the title of a new Public Affairs Pamphlet reporting on the development of such services. It is also the title of a new film that uses the documentary technique to show how an Information and Referral Service works. The pamphlet (No. 428), written by Elizabeth Ogg, may be obtained for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N. Y. 10016. The film was produced on a grant from the U. S. Public Health Service.

The pamphlet underscores the need, in this time of rapid social change, for Information and Referral Services to direct people with problems through the maze of health and welfare agencies to the one that can best help them. Aside from the fact that the person in need—or the clergyman or doctor he has consulted—does not always know the most appropriate solution, Miss Ogg points out, "the search for service is often misdirected because the seeker has failed to see his key problem in clear focus . . . People need first and foremost a skilled counselor with intimate and accurate knowledge of all the local agencies to help them sort out their most pressing problems and suggest what they can do."

Auspices for such a service vary from state to state, from city to city. In some places, it may grow out of services to the elderly; in others, it might be concerned with health, convalescent, and rehabilitation needs; in many low-income communities, Information and Referral Services have evolved as part of Neighborhood Service Centers, most of which have been funded by the Office of Economic Opportunity. In its day-to-day work, the Service also serves a second important function, as "the eyes and ears of community planners, bringing them word of gaps and overlaps in services."

For areas that do not already have an Information and Referral Service, Miss Ogg provides guidance on how to go about setting up such a program. She suggests questions to consider relating to auspices, purpose and program, financing, staff, use of volunteers. But beyond these considerations, she stresses that the needs of "the many who don't know where to turn" must always be paramount. □

SECTION 

OPHTHALMOLOGY

OCTOBER 1969 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

DR. BOLGER SERVES CARIBBEAN ISLAND

Dr. James V. Bolger, Waukesha, recently spent a month doing volunteer work to establish an eye clinic on the Caribbean Island of St. Lucia in the West Indies.

His account of the trip follows:

"The clinic had its formal opening this spring, but its development was largely due to the efforts of Dr. Frederick Stephens of Providence, R. I., who was down there last year and was the first ophthalmologist to visit this part of the island for many, many years.

"What impressed me most of all, besides the well-run administration and physical plant that the sisters (Convent of the Sorrowful Mother in Milwaukee) have developed from nothing, was the absence of infectious ocular problems. We saw our share of cataracts, pterygiums, and glaucoma, but most patients visiting the clinic had symptoms of burning and smarting, and so a great deal of zinc plus decongestant preparations were administered.

"The greatest need, as I saw it, was for some type of optical services to be made available. We did have many stock lenses and frames sent down to the clinic through the Eyes for the Needy Organization of New Jersey, but many more people could not be adequately provided glasses because of their unusual refractive disorders.

"The cost of the glasses at Castries, several hours away by bus, was prohibitive; so most patients, if they were not furnished glasses, could not get them, as the monthly income of those who were gainfully employed was probably no more than $60 to $80 per month, and a bifocal correction in Castries may cost $45 to $50.

"In order to solve this optical problem, we are having one of the Eye Clinic employees, a St. Lucian called 'Cuthbert'—whose primary duty when I was there was to act as interpreter with the French-patois-speaking natives—come up this fall for a three-month course in opticianry that we have arranged, so that he will be able to go home and serve the needs of the Eye Clinic as an optician." (Any financial assistance in this endeavor will be greatly appreciated by Doctor Bolger who hopes some "angels" will underwrite his transportation, although he plans to be responsible for Cuthbert's room and board.)

"I believe our experiences were no different from most any volunteer doctors in this area. It was diversionary and interesting for my family and gave us a high degree of satisfaction in doing this work. This can be a family project, as my 19-year-old son, a junior in premedicine at Northwestern, also was there, and he helped with vision screening at the Clinic."

UW RESIDENTS COMPLETE TRAINING

Two University of Wisconsin residents completed their ophthalmology residency Sept. 1. Dr. David Harper has joined the Duluth Clinic in Duluth, Minn. Dr. David Stinchcomb will practice in Arizona after doing ophthalmology work at several missionary hospitals in India this year.

LOW VISION CLINIC

The Low Vision Clinic at 750 North 18th Street, Milwaukee, recently announced that Dr. Philip Taugher has been appointed clinic director and clinic ophthalmologist.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

Dr. Mansour Armaly, Professor of Ophthalmology at the University of Iowa and Director of Glaucoma Services, will be the guest speaker for the Milwaukee Ophthalmological Society Tuesday evening, Nov. 25, at 6 p.m., University Club, Milwaukee. Doctor Armaly also will conduct resident rounds the following morning as visiting professor of ophthalmology at Marquette School of Medicine. These rounds are to be held from 9 until 12 noon, King Conference Room, Milwaukee County General Hospital, and all ophthalmologists are invited to participate.

The program for the coming year of the Milwaukee Ophthalmological Society is as follows: Nov. 25—Mansour Armaly, MD, University of Iowa; Jan. 27—University of Wisconsin; Feb. 24—Marquette University; Mar. 24—Hans Zellweger, MD, University of Iowa, Pediatric Department; Apr. 28—Robert Ellsworth, MD, (tentative) New York; and May 14—David Cogan, MD, Boston, Mass.

The officers of the Milwaukee Ophthalmological Society for the 1969–1970 year are as follows: president—Dr. James V. Bolger, Waukesha; vice-president—Dr. Thomas R. Sawyer, Milwaukee; secretary—Dr. Howard W. Fiedler, Milwaukee; and treasurer—Dr. Harry A. Easom, Milwaukee. □

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Pathologic Fractures in Children

GUNNAR GUNDERSEN
Festschrift

WISCONSIN MEDICAL JOURNAL
NOVEMBER 1969

By JOHN W. HAYDEN, M.D.
La Crosse, Wisconsin

■ *Long before coming to Wisconsin I had heard many favorable things concerning the Gundersen Family and the Gundersen Clinic. Their abilities as physicians who have rendered consistently excellent medical care to the surrounding community is well known throughout the nation. It seems that Dr. Gunnar Gundersen was encouraged to practice Orthopaedic Surgery by his father. When I arrived at the Gundersen Clinic some time ago, I found that orthopaedic surgery in the Clinic was quite well established already due to Dr. Gunnar's efforts. This is but one facet of his many accomplishments and even though he was involved in State and American Medical Society activities, he continued to be active as a physician, well respected by his community and his peers. It is indeed an honor to be asked to contribute to this special issue of the Wisconsin Medical Journal commemorating Dr. Gunnar Gundersen an article which has to do with that branch of surgery to which he devoted much of his lifetime.*

JOHN W. HAYDEN, M.D.

PATHOLOGIC FRACTURES in childhood connote benign conditions whereas in the adult, fractures of this sort usually indicate malignant disease. Certain pathologic fractures occur only in childhood because of developmental aspects. In general, a *pathologic fracture* occurs as the result of minimal trauma to bone affected by new growth or tumor or in abnormal bone with less than the normal amount of elastic resistance to various types of stress. A *fatigue fracture* occurs in normal bone as a result of repeated, rhythmical, subthreshold traumata.

In childhood, pathologic fractures due to localized causes are most frequently associated with a benign solitary bone cyst or less commonly to a variety of other causes listed in Table 1. Leukemia, neuroblastoma, sarcomata, and so forth, are implicated in fractures of this sort in the terminal phases of the respective disease if at all. *Fatigue fractures* in children occur around the knee usually and are associated with new bone formation whereas in the adult, the most common location is in the metatarsal. Less frequent locations of fatigue fractures are the fibula, humerus, first rib, femoral neck, and patella.

When one encounters a child with a fracture believed to be pathologic, the usual care is begun by splinting the part and providing analgesia while a careful history is taken to determine what events led up to the fracture. It is also helpful to know the number of previous fractures in the same or other bones, or whether there has been previous gait

From the Department of Orthopaedic Surgery, Gundersen Clinic, Ltd.

Reprint requests to: John W. Hayden, M.D., Gundersen Clinic, Ltd., 1836 South Avenue, La Crosse, Wis. 54601.

TABLE 1—*Causes of Pathologic Fractures in Childhood*

Localized Process	Generalized Process—Insufficiency Fracture
Solitary Unicameral Bone Cyst	*Generalized Bone Disease*
Fibrous Dysplasia	Osteogenesis Imperfecta
Aneurysmal Bone Cyst	Hypophosphatasia
Giant-Cell Tumor	*Metabolic Disorder*
Eosinophilic Granuloma	Scurvy
Congenital Pseudarthrosis of the Tibia	Rickets
	Hyperparathyroidism
Primary Malignant Tumor	*Arthritis and Inflammatory Conditions*
Metastatic Tumor	Rheumatoid Arthritis
	Osteomyelitis
Stress Fractures	*Neurotrophic Disease*
	Myelomeningocele
	Poliomyelitis
	Syringomyelia
	Other
	Gaucher's Disease

disturbance, progressive deformity of extremities, and the like. If one suspects some rare disease affecting bone, other aspects of history such as appearance of café au lait spots, early menstruation, can also be covered. It is very important to know the account of the actual incident causing the fracture described by the parent or child to establish the degree of force involved. The review of systems, the general and orthopaedic examinations will often lead one to the correct diagnosis prior to procurement of laboratory and x-ray studies. Each of the fairly rare diseases has its characteristic physical findings and involvement of other systems. Routine laboratory studies, and if indicated, calcium, phosphorus, and acid and alkaline phosphatase levels, are procured.

The roentgenographic appearance of the fracture area may take several forms from that of a large soft tissue calcareous mass as seen frequently in osteogenesis imperfecta to that of no apparent visible abnormality whatsoever, as with a fatigue fracture. Bone may be of variable density, soft tissues may reveal very scant muscular tissue or large cystic cavities surrounded by a shell of bone, the neighboring joint may be deformed, or there may be a displacement of an epiphysis. The bone may be straight or may be bent or broken in more than one area. A skeletal survey may reveal other abnormalities in other bones. An arthrogram in the young infant may clarify cartilaginous abnormalities in the joint which might not otherwise be appraised. Finally, if one is still unable to make the diagnosis for the cause of fracture, biopsy of the bone in the area of the fracture or marrow from the sternum or ilium will usually establish a histologic diagnosis.

Treatment, therefore, is directed toward the basic cause when possible as well as toward the fracture itself. For the most part, pathologic fractures can be treated conservatively by traction and/or splinting, by the use of a cast or sling and swathe to maintain length and alignment until union occurs. Usually the fracture will unite unless associated with a neurofibromata or malignant process. Treatment in the latter condition is usually expectant and conservative.

Fractures Due to Localized Process

The *solitary unicameral bone cyst* is the most frequent benign cause in children of pathologic fracture due to localized process. The lesion usually appears in the proximal humerus or the proximal femur and is dependent for its being and enlargement on the abnormal performance of the associated epiphyseal plate. It is central and does not erode or expand bone usually, and is ordinarily metaphyseal or diaphyseal in location. The lesion rarely traverses the epiphyseal plate and is rarely healed following fracture. The usual life history of the lesion is variable in that its time of appearance during growth and its period of enlargement are not predictable.[1] When the cyst appears in the metaphysis, one wall of which is made up of the epiphyseal plate, the lesion is felt to be in the active or enlarging phase.[2] Surgical procedures in this stage nearly always fail and recurrence of the lesion occurs. As the adjacent epiphyseal plate begins, for some unknown reason, to elaborate normal bone and with growth becomes separated from the cyst, the lesion is designated as being in its *latent* or *inactive* phase or is no longer enlarging.[2] Surgical procedures to obliterate the cyst such as curettage and bone grafting in this stage usually will result in healing of the lesion.[1] Many other bones in the skeleton may be involved by this process but flat bones are very rarely involved.

Some exceptions in the usual life history of the cyst should be mentioned. *First* is that of enlargement of the cyst when it is no longer associated with the epiphyseal plate. This is usually not of very great magnitude but when it occurs the disease process is probably different from that of a standard solitary unicameral cyst. Curettage and grafting in this particular instance will usually result in healing of the lesion.

The *next* exception is that of expansion of the solitary cyst through the epiphyseal plate. When this occurs, the epiphysis fails to grow and contribute length to the bone; however, it will usually continue to grow at the periphery and cause enlargement of the rim of the involved area. Bone grafting following curettage usually fails to obliterate the lesion.

Occasionally a benign cyst will appear to be separated from the epiphyseal plate from which it originally had a relationship, but in reality on closer examination, a small channel will be found connecting the cyst to the epiphyseal plate. Attempts at curettage and grafting in these lesions will end in failure of healing of the lesion.

The *last* variation is that of healing or obliteration of the cyst following fracture which occurs in inactive humeral cysts in approximately 4% of the lesions.

Pathologic fractures in solitary cysts occur more often during the active phase than during the inactive phase. As noted above, treatment can be instituted in a conservative fashion to maintain alignment and length of the bone until healing of the fracture occurs. The fractures in the upper extremi-

ties are best treated by the use of sling and swathe or hanging cast, or in the lower extremities by application of suitable traction. In the lower extremity, traction is continued until early callus is formed and a plaster cast is utilized until union is complete. Following this, a pattern-bottom splint may be used for non-weight bearing until the bone in the area becomes quite firm or the lesion becomes inactive so that it may be operated. Occasionally, it may be necessary to advise the family that surgical treatment of the active lesion should be undertaken to provide stabilization of the cystic area until such time as the epiphyseal plate begins to elaborate normal bone. It is preferable to treat the lesion surgically in the inactive phase; however, if repeated fractures and deformities have occurred, perhaps adding a bone graft during the active phase may add some needed stability until the lesion becomes latent. Other forms of therapy such as curettage, curettage with cauterization or packing with plaster have usually not met with success in healing of the lesion.

Fibrous dysplasia is a disease of unknown origin that may involve one or many bones by replacement in the medullary cavity by a fibro-osseous mass causing thinning and expansion of the overlying cortex. It may be associated with abnormal pigmentation of the skin, and in the female, precocious sexual development and early skeletal maturation. It is most common in childhood, but may occur in adults. The lesions in the adult tend to be monostotic. Limp, pain in the leg, or fracture are the initial symptoms in about 70% of the cases. Abnormal vaginal bleeding occurs in a large portion of female children. Leg length discrepancy is the most common physical deformity associated with bowing of the affected femur and with increase in length on the side of the unilateral involvement. Patients usually have no abnormality in peripheral blood level except for an occasional elevation of alkaline phosphatase unassociated with the amount of skeletal involvement or of fractures.[3]

The clinical course of the disease is marked usually by fracture. Eighty-five percent of the patients in one group had at least one fracture.[3] There are some who never sustain a fracture although a large portion of the skeleton may be involved. There seems to be no sparing of the individual from further fractures at the time of puberty as is seen in osteogenesis imperfecta. Those involved with the disease at an early age progress rapidly and have increased deformity, while those in whom the disease is noted later in childhood develop only minimal deformity. X-ray films of the bone reveal asymmetrical focal thinning and expansion of the cortex, advanced skeletal age associated with polyostatic dysplasia found before puberty. Skull density is increased at the base with thickened occiput. Frontal and sphenoid sinuses are many times obliterated, occasionally causing displacement of one orbit inferiorly. Epiphyseal lesions are seen most commonly after puberty. The extension of the lesions is seen in three forms—by the occurrence of new lesions in the pelvis and ribs before and more often after puberty, expansion of existing lesions, and increasing deformity of involved lesions. Pathologic fractures are seldom displaced and healing is not delayed. It is important to try to maintain length and alignment until union has occurred. Lesions in the shaft and bowed deformities in the shaft are best treated by curettage, bone grafting, and internal fixation. All surgical measures should be integrated into a comprehensive orthopaedic program for prevention of deformity. Customary lack of involvement of the femoral head makes nail plate fixation feasible in the shepherd's crook deformity after closure of the epiphyseal plate. Osteotomy, Küntscher nail fixation, and bone grafting of the bowed femoral shaft are the procedure of choice. Leg length discrepancies are corrected by appropriate epiphyseal arrest. Because of the presence of more rapid growth on the side of the involvement and associated deformities elsewhere in cases of polyostotic involvement, the decision as to the time of epiphyseal arrest becomes a matter of fine judgment.[3]

Aneurysmal bone cyst is an infrequent benign lesion which occurs eccentrically in the metaphysis of long bones, but occasionally in the spine and in flat bones produces local bone pain and expansion of bone. The lesion is filled with very vascular fibrous tissue and osteoid with giant cells, and occurs in children as well as adults under 30. The roentgenographic appearance reveals an expanding bone lesion with a thin shell of bubbly new bone surrounding the periphery of the tumor. Treatment of the fracture is conservative as with bone cyst or fibrous dysplasia. The treatment of the lesion is curettage and insertion of bone grafts with use of suitable immobilization following the procedure. Areas that cannot be reached by surgical treatment as in the spine, roentgen therapy in the range between 600 and 2,000 roentgens may be employed followed by the use of appropriate body cast or suitable brace until healing occurs.

Giant cell tumor may be associated with pathologic fracture which is commonly thought to be present in patients no younger than 20 years of age. However, this lesion has been noted, under the age of 20, in 11 of 41 patients reported by Dudley, et al —28 were female, 3 of the group had pathologic fractures.[4] The lesion causes expanding destruction of bone commonly about the knee and frequently involving the epiphysis. Fractures are treated conservatively. Curettage alone is usualy not enough to affect cure of the lesion. Block excision with autogenous bone graft or excision of an expandable bone is the procedure of choice. When joint surfaces are removed, the defect may be replaced by an appropriate prosthesis. Irradiation should not be carried out in the benign variety. Recurrences of this tumor carry with it the ominous possibility of malignancy.

Eosinophilic granuloma may cause radiolucent lesions of bone and may be responsible for pathologic fractures. The basic process of Histiocytosis-X is common to all three forms of the disease—the socalled Hand-Schuller-Christian disease, Letterer-Siwe disease, and eosinophilic granuloma.[5] In eosinophilic granuloma the involvement of bone is less marked than in the other forms and usually involves bones alone. It may involve only a single bone or occasionally several bones. The latter process was described in 1940 by Jaffe and Lichenstein.[2] Most of the cases are seen in childhood or adolescence or maybe even adult life. Males are more often involved and in almost half the cases, the frontal bones are involved. Lesions are almost always found in bones closest to the trunk and almost never involve the small bones of the hands or feet. When it involves the spine, it may cause the socalled vertebra-plana. The lesion itself appears to be a punched out area, with no bony sclerosis or reaction about it. The lesions may be of any size, although usually quite small. Occasionally it may involve the epiphysis, but it is usually in the diaphysis or metaphysis of long bones. The cortex is not expanded, but may be destroyed. The edge of the lesion may be well outlined and benign appearing. The treatment of this disease is by establishing diagnosis by biopsy, as well as history of physical examination, and the like, and of local roentgen therapy; although curettage may be the treatment of choice in the extremities or in an area where epiphyseal lines or ovaries might be affected by the roentgen therapy.

Congenital pseudarthrosis of the tibia is a rare condition which follows pathologic fracture, the latter occurring before or at birth, or during infancy, childhood, or adolescence. It is most commonly found during early childhood. The same process may also involve the ulna, the femur, the first rib, clavicle, fibula, and the most commonly the tibia. The usual sequence of events is anterior bowing of the tibia usually at the junction of the middle and lower thirds and present at or shortly after birth. Bowing increases but the fibula remains straight. Spontaneous fracture occurs after mild trauma or ill-advised osteotomy is done. Following this the fracture fails to heal and resists healing with the usual methods of conservative treatment. After this the fibula fractures. The etiology of this condition is felt by some[6] to be due to a localized neurofibroma or fibrous dysplasia by others.

About 50% of the patients have a fracture during the first year of life, and 25% during the second year, and the remainder before eight years. There are two other conditions of childhood causing bowing of the tibia. The first is congenital tibial kyphosis which is postero-medial bowing of the tibia and fibula seen at birth which is not associated with obliteration of the medullary canal as is seen in congenital pseudarthrosis of the tibia. This condition straightens out on its own and requires no treatment. The other is congenital absence of the fibula with anterior bowing of the tibia. The overlying dimple in the skin and associated congenital anomalies of the foot will usually render the proper diagnosis. This condition, if necessary, may be treated by osteotomy quite safely.

Treatment of congenital pseudarthrosis of the tibia as outlined by Soffield involves removal of the tibial diaphysis, bone ends reversed, and a graft added associated with excision of the soft tissue and fibrous material at the pseudarthrosis site.[7] Following this the fragments are threaded on an intramedullary rod which is then placed between the two epiphyses. Appropriate cast immobilization is continued until healing is complete which happily is accomplished in a high percentage of cases so treated.

Fractures Due to Generalized Disease—Insufficiency Fracture

Osteogenesis imperfecta is manifested as a congenital or late (tarda) variety, the latter of which seems heritable and associated with other defects such as deafness in the second decade and blue sclerae. This disease has the happy occurrence of decreasing the number of fractures after adolescence is reached. The main problem in these children is that malunion and deformity develop following the many fractures that occur. Long-range comprehensive orthopaedic program should be instituted toward maintenance of alignment and length of bone following fractures until adolescence is reached. Tiny children with the severe form of this disease can be treated effectively with a portable traction frame that the parents can use at home to care for repeated fractures without having to come to the hospital. Hyperplastic callous formation is noted in this condition and should not be over-diagnosed. Angular deformities due to malunion seen in the adolescent can be corrected by the fragmentation and osteotomy with intramedullary rod fixation of Soffield.[7]

Another condition similar to osteogenesis imperfecta is *hypophosphatasia,* a chronic familial disease with low alkaline phosphatase levels in the serum and tissues associated with extreme undermineralization of bone in the infant and, in the less marked varieties, a persistent rickets-type appearance of long bones. These people should never, if at all possible, be subjected to operations on the skeleton since nonunion is quite common.[8] Treatment again is the same as that of a child with osteogenesis imperfecta, that is maintenance of alignment and length of the pathologic fractures by any conservative nonoperative method that can be employed.

There is an insufficiency fracture that is associated with *scurvy.* Although rare now, it does occur in children with allergy to orange juice when replacement therapy is not provided by the physician or parent or in children whose orange juice has been boiled by the mother. Scurvy usually occurs between the ages of six months and a year at a time when rapid growth is occurring. There are subperiosteal

hemorrhages and displacement of epiphyses. Conservative care, splinting of the parts if necessary, and adequate doses of ascorbic acid result in healing of the lesion.

Another disease should be emphasized since it is pathologic and involves many bones and occurs about the same age range as does scurvy and many times is thought to be scurvy by those who observe the child. Usually a child is brought in because of "spontaneous" bruising, usually one or more fractures of the limb bones, clavicle, or ribs, irritableness of the child, and unexplained swelling of the limbs. The child may exhibit a temperature of 100 F to 101 F with moderate leukocytosis. All of these children are under one year of age and unable to speak for themselves. The bones visualized by the roentgenograms appear to be quite normal except for multiple fractures at various stages of healing and associated dislocation of epiphyses. This is the socalled *battered baby syndrome* and the pathogenicity usually lies in the parent, or in a jealous sibling.[9]

These children improve remarkably, of course, while in the hospital and develop no new lesions. In the young infant, injuries of the elbow or hip may be delineated by an arthrogram. It is of utmost importance to recognize this problem since some 10% of the children discharged to the same environment die of the same mistreatment. The extremity injuries are produced by pulling or even by swinging the child by the foot or hand causing violent rotary stress, at the metaphyseal area and joint capsule. The point of impact is the chest or head. Management of this condition, of course, is the protection of the child by appropriate investigating authorities, as well as maintenance of alignment and position until union of the fractures occurs by the use of traction and/or plaster cast.

In fractures associated with myelomeningocele, the neurological deficit is in the lower extremities and associated with osteoporosis. Fractures are suspected only by discovery of angular deformity or local warm swelling of a portion of a lower extremity. Treatment must be carefully guarded so that further damage in the form of pressure sores in dependent and contact areas does not occur. In older children skeletal traction may be the treatment of choice.

In those children with chronic poliomyelitis, fractures in the lower and upper extremities occur as the result of a fall in which the osteoporotic bone of the paralyzed limb breaks with ease. Conservative immobilization of the fracture fragments results in rapid union. There is usually little more than minimal displacement at the fracture site.

Gaucher's disease may also be implicated in pathologic fractures in children—especially in the adolescent chronic form of the disease. The Gaucher cells replace marrow and are responsible for the familiar Erlenmeyer flask appearance of the femurs and spontaneous fractures of the vertebrae and of long bones. The coxa plana like picture occurring in the capital femoral epiphysis is one of the hallmarks of this disease and is caused by compression of vessels entering the femoral head through the epiphyseal plate by the Gaucher cells in the marrow cavity. Acid phosphatase levels of the serum may be elevated. Surgery in these children is not in order because of the possibility of producing a chronic draining sinus.[10] Measures such as traction and relief of weight bearing to prevent deformity are important. Fractures should be treated conservatively, and episodes of pain by periods of bedrest. The coxa plana like process of the capital femoral epiphysis is best treated by conservative methods of bedrest, traction, and later, a non-weight bearing patten-bottom splint.

Stress Fractures

Stress fractures are those which occur in normal bones, that have been subjected to repeated subthreshold rhythmical traumata. These fractures occur in the weight bearing bones, namely: the metatarsals, calcaneus, tibia, fibula, femoral shaft, femoral neck, and os pubis; and in the non-weight bearing bones: the ulna, first rib, patella, humerus.[11]

In this condition, the pain is localized in bone, is insidious in onset, worse on activity and better on rest. There is usually no history of a violent accident or single injury that can be implicated. The injured area is tender, swollen, and sometimes warm. Should stress continue, the incomplete fracture may be converted to a complete fracture. The pattern of stress fractures in the child is different from that in the adult. In children the region of the knee is frequently affected and the type of lesion varies with the age of the child. Stress fractures may resemble malignant or infectious processes and may even require biopsy in order to clarify the processes since the callus may be large and may extend well up or down the shaft from the actual area of involvement. In a child bones most frequently involved are the tibia and fibula. The usual site for involvement in the tibia in the child is in the upper third posteromedially since the lateral aspect is somewhat supported by the fibula so there is less periosteal reaction on this side. This compression fracture causes a limp of gradual onset and is best treated by rest or prevention of further stress by a long-leg cast. Stress fractures of the femoral neck seldom occur before 18 years of age and rarely before the capital epiphysis is closed. The humerus is involved in boys usually after some vigorous exercise such as throwing a ball or playing tennis. Fatigue fractures of the fibula have been associated mainly in cross-country runners and may occur at any age and involve the lower third. Those of the patella occur in adolescent boys as a result of vigorous exercise and are best treated by excision of the fragment.[12]

Summary

In treatment of pathologic fractures in childhood, it is imperative to make the correct diagnosis of the basic process, treat the fracture conservatively if at all possible, treat the basic process, avoid operation in congenital tibial kyphosis and congenital pseudarthrosis, Gaucher's disease, and hypophosphatasia. Angular deformities of extremities should be corrected by the recommended surgical methods in adolescence. The solitary bone cyst should be treated by curettage and bone grafting in the inactive stage. The treatment of fatigue fractures is conservative, care being taken not to over diagnose the condition. Operation rarely, if ever, is indicated.

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A TEN-YEAR STUDY OF 5-FLUOROURACIL IN DISSEMINATED BREAST CANCER WITH CLINICAL RESULTS AND SURVIVAL TIMES

F. J. ANSFIELD, MD, GUILLERMO RAMIREZ, MD, SANFORD MACKMAN, MD, G. T. BRYAN, MD, and A. R. CURRERI, MD, University of Wisconsin Medical School, Madison, Wis.: *Cancer Res* 29:1062–1066 (May) 1969

The survival data of 676 patients with widely disseminated breast cancer treated with 5-fluorouracil (5-FU) alone or with any additional therapy during the decade 1957–1967 were analyzed.

Only postmenopausal women were given chemotherapy as in the premenopausal patient with advanced breast cancer, oophorectomy is considered the treatment of choice.

Improvement, which included at least a 50% reduction in accurately measurable lesions, was observed in 23.1% as a result of 5-FU therapy and continued for an average of 10.3 months. This group had a median survival of 29 months from the onset of therapy. An additional 23.1% had less than a 50% regression or their lesions were unaltered with 5-FU therapy. This group was categorized as unchanged and this status persisted for an average duration of 7.4 months, with a median survival of 26 months. Progression occurred in 53.8% and this group had a median survival of 9 months.

Patients who failed on 5-FU were offered other therapy, the sequence depending upon the menopausal age. In those less than five-years postmenopausal, after 5-FU, cyclophosphamide (Cytoxan) was employed followed by an androgen which was last in the sequence as sex hormones are least effective in the younger woman.

Patients more than five-years postmenopausal can properly be treated initially with sex hormones as they are significantly more effective in the older women. Next in the sequence, 5-FU was employed followed by Cytoxan and ultimately secondary hormonal therapy including corticosteroids.

A number of papers have reported a significant enhancement in survival times in patients with disseminated breast cancer that responded to sex hormones or ablative procedures. This report, in a substantial series of patients, is apparently the first to show a significantly longer survival in patients who improved or were unchanged as compared to those who failed on treatment with a cytotoxic compound. One can state that almost half the patients with advanced breast cancer treated with 5-FU are afforded worthwhile palliation. □

FROM THE LITERATURE

CHEMICAL DIABETES criteria—Public Health Service, Fajans and Conn, Mosenthal and Barry-evaluated for accuracy in predicting development of classic diabetes in 352 patients over 12-year period. P.H.S. standards (FBS-110 mg%; one-hour—170 mg%; two-hour—120 mg%; three-hour—110 mg%) gave best results, with 52 per cent accuracy, and were considered best standard for diagnosis. —John B. O'Sullivan, et al., *New Eng. J. Med.*, May 9, 1968. □

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HYPOPHYSECTOMY

The Technic of Choice for Diabetic Retinopathy, Pituitary Tumors, and Metastatic Breast Cancer

By C. NORMAN SHEALY, M.D.
La Crosse, Wisconsin

■ *Dr. Gunnar Gundersen is now the best known of a family of outstanding physicians. Indeed, I think the Gundersens have produced more excellent physicians than any other family in America. Even more important, through the efforts of Doctor Gunnar, his father, his brothers, and their sons, they have nurtured a clinic which, as only an adolescent, is fast coming to maturity. The Gundersen Clinic offers a happy climate for productive clinical practice, teaching, and research. All who know the family love and admire them.*

C. NORMAN SHEALY, M.D.

As recently as 1967 Francis Moore,[1] in an extensive review of methods for palliation of breast carcinoma, felt that the hazards of hypophysectomy were greater than oophorectomy and adrenalectomy. Unfortunately he was unaware of recent improvements in technic which make hypophysectomy one of the safest operations now performed.

A great variety of approaches to the pituitary fossa have been tried.[2-10] The transsphenoidal approach to the gland was first suggested by Zuckerkandl.[11] Surgically it was practiced by Kanavel,[2] Hirsch,[3] and Cushing[4] only to be abandoned because of a poor choice of openings, inferior technics of suction, and lighting and sepsis. Transfrontal hypophysectomy, introduced by Frazier[5] and popularized by Cushing, is a procedure dear to the hearts of most modern neurosurgeons. However, it carries the stress of a frontal craniotomy, at least some removal of scalp hair, and technically is considerably more hazardous than a properly performed transsphenoidal procedure. Furthermore, patients and medical colleagues find the invisible incision much more palatable esthetically.

A variety of methods for approaching the gland even transsphenoidally are available. All these have inherent problems except the submucosal sublabial infranasal approach first used by Dott[12] for tumors. It was later practiced by Guiot[13] who taught Hardy[14] the technic. We were fortunate to have the procedure introduced to us by Dr. Charles Drake and Dr. Jules Hardy who also used it initially for tumors. Later Hardy saw the great advantage for removal of normal glands. Since our initial view of the operation, we have felt it to be the ideal approach for removal of the normal gland as well as for most pituitary tumors. An experience with 61 cases has confirmed this view.

Current Series

Sixty-one patients have been operated by the submucosal infranasal transsphenoidal approach to the hypophysis. Indications have been the following:

Carcinoma of breast	30
Carcinoma of prostate	4
Diabetic retinopathy	15
Acromegaly (eosinophilic adenoma)	5
Chromophobe adenoma	7

The surgical procedure was described in a previous paper.[15] Essentially it allows an incision beneath the upper lip at junction with gum mucosa. Dissection then proceeds beneath the mucosa along the path of the nasal cartilage to the sphenoid sinus. The sella turcica hangs down in the sphenoid sinus. The gland then lies only 3½ to 4 inches deep to the mucosal opening. Special retractors and lights allow such excellent visualization that *all* 6 faces of the sella can be visualized. The pituitary fossa

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can be totally examined for any residual gland. Another advantage is low section of the pituitary stalk; this minimizes diabetes insipidus.

In giant tumors total excision is not always possible. The inferior approach, however, allows better visualization and normal pulsations of the brain force tumor down into the open sella. Traction on hypothalamus and other vital brain centers is thus avoided. In the largest tumors we have on two occasions planned two-stage procedures to take advantage of this natural tendency of the tumor to fall gradually postoperatively into the empty hole at the bottom of the skull.

In only four cases was incomplete removal of a normal gland effected. Three of these were among our earliest patients. At the present time total removal is assured by the use of binocular loupes or the dissecting microscope.

The only worrisome complication was cerebrospinal fluid rhinorrhea present in 6 patients, an incidence of 10%. This is a nuisance, to be sure, but if treated promptly it is of no serious consequence. Adequate antibiotic coverage has obviated the risk of meningitis. There has been no operative mortality.

Discomfort to patients is minimal. Headache occurs about 60% of the time; almost invariably it clears by the time the nasal packs are removed on the 4th or 5th postoperative day. Otherwise management of patients is done in a routine fashion for patients with hypopituitarism. By the time of discharge from the hospital, steroid replacement consists of 5 mg of prednisone twice a day. This is reduced to a daily dose of 7.5 mg at a six-week follow-up by which time it is usually advisable to begin thyroid replacement, after a protein-bound iodine is determined.

Significant pain and the gastrointestinal problems of an abdominal approach are avoided. Overall, patients are subjected to far less stress than a combined oophorectomy and adrenalectomy. There is the added advantage that hypophysectomy probably gives a longer remission in breast carcinoma than the other two procedures.

In diabetics transsphenoidal hypophysectomy has, perhaps, its greatest superiority. These patients are particularly fragile. Thus the simpler, shorter, less stressful operation is much better tolerated than is a craniotomy.

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WORLD RENOWNED CARDIOLOGISTS EVALUATE RESULTS OF SURGERY

A symposium, in which some of the world's outstanding cardiologists evaluated the results of surgical treatment of cardiac lesions, has been published by the American Heart Association as No. 22 in its Monograph Series. The meeting was held in conjunction with the Fifth World Congress of Cardiology in New Delhi, 1966.

The publication, "Evaluation of Results of Cardiac Surgery," which assesses the effectiveness of surgery in heart disease treatment, was edited by Drs. Lewis Dexter and Lars Werko. It may be obtained through local Heart organizations or the AHA National Office, 44 E. 23rd St., New York, N.Y. 10010.

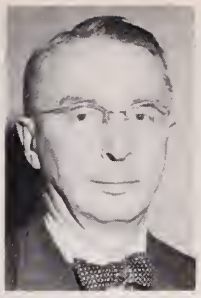
WISCONSIN HEART ASSOCIATION: 205 West Highland Ave., Milwaukee, Wis. 53203. □

CLINICAL CENTER STUDY OF CYSTINOSIS

The cooperation of physicians is requested in the referral of patients with cystinosis to participate in studies being conducted by the National Institute of Arthritis and Metabolic Diseases at the Clinical Center, National Institutes of Health in Bethesda, Maryland.

Of particular interest are pregnant women who are mothers of cystinotic patients. There is reason to believe that in-utero diagnosis of cystinosis can be achieved. Thus we are especially interested in studying women, as early in pregnancy as possible, who are at risk for giving birth to a cystinotic child.

Physicians who wish to have their patients considered for these studies may write or telephone: JARVIS E. SEEGMILLER, MD or JOSEPH D. SCHULMAN, MD, Clinical Center, Room 8-D-19, National Institutes of Health, Bethesda, Md. 20014; tel.: 496–4781 (Area code 301). □



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Familial Occurrence of Chondrocalcinosis

(Pseudogout Syndrome)

By EDWARD L. PERRY, M.D.,
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and KERMIT L. NEWCOMER, M.D.
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■ *It is an honor and a pleasure to be contributors to this issue of the* Wisconsin Medical Journal *honoring Dr. Gunnar Gundersen, a son of the founder of the Gundersen Clinic and a prime mover in the development and growth of the Gundersen Clinic and Foundation. He has been both good friend and colleague. His contributions to organized medicine and to the practice of medicine in La Crosse, in Wisconsin, and in the U.S.A. have been of real significance. Although a general surgeon, orthopedics and arthritic disease have been among his prime interests.*

EDWARD L. PERRY, M.D.
EDWIN L. OVERHOLT, M.D.
KERMIT L. NEWCOMER, M.D.

THE SYNDROME OF PSEUDOGOUT, associated with chondrocalcinosis, has been recognized with increasing frequency.[1-8] These attacks may mimic acute gout or other types of arthritis. However, the uric acid and rheumatoid factor determinations are usually normal, and recently it has been shown that the crystals obtained from aspirated joint fluid are calcium pyrophosphate. The authors have had the opportunity to follow a father and son with this syndrome over the course of several years.

Case Reports

Case 1. A Caucasian man had had episodic attacks of rheumatism since 1933. In February 1951, at age 52, he had had a two-week episode which was severe enough to require the use of a cane. He was first seen at our clinic in May 1952 when he had an attack persisting for eight weeks. This began with swelling and pain in the feet and then rapidly spread to the arms, shoulders, and hip. His pain was most severe in the late afternoon and early evening and less severe in the early morning hours. Cortisone had been given orally without relief. Aspirin produced partial and temporary benefit. He was a farmer and drank raw milk. However, there was no history of undulant fever in his cattle. Two half-brothers had some type of rheumatism.

Examination revealed a thin, alert man without evidence of joint deformity. Knees, ankles, and feet were cold and bluish and very tender with motion. Enlarged lymph nodes of 1 to 1.5 cm in diameter were noted in axillary and inguinal areas. Laboratory tests showed the following values: hemoglobin 12 gm/100 ml; white blood cell count (WBC) 9,400 per cu mm; sedimentation rate 85 mm in one hour, and urinalysis was negative. Agglutination test was negative for *Brucella abortus*. Uric acid was 3.5 mg/100 ml and an x-ray film of the chest was normal. X-ray studies of the feet showed a slight rarefaction near the head of each first metatarsal, compatible with early gouty arthritis.

Treatment was initiated with cortisone, 75 mg daily, and aspirin, 2 gm daily. Within a week he was able to get out of the wheelchair and use crutches. Two weeks later he was walking unassisted, although he was still having pain in the feet. The cortisone was reduced to 50 mg daily. A month later he was working, although he was still having swelling of his feet at night. Cortisone therapy was discontinued, and he maintained improvement on aspirin.

On Jan. 14, 1968, he was hospitalized (at age 70) because of recurrence of arthritis. He complained of morning stiffness involving particularly the hands, wrists, feet, and ankles. There was some limbering up with activity. He had been seen at another hospital where he was treated with aspirin and indomethacin. However, these were of limited benefit.

Examination revealed inability to completely extend the left leg at the knee joint. The left ankle was almost completely stiff and the right showed very little movement. There was incomplete extension at the elbow joints. The right wrist was enlarged and motion was restricted at both wrist joints. The involved joints were minimally deformed and there were no fusiform deformities of the fingers. Ro-

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Fig. 1—Left knee showing calcification of the articular cartilage. The right knee showed similar changes.

Fig. 2—Right wrist. Note the calcification of the cartilage at the end of the ulna and radius. The left wrist was similarly involved.

entgenograms showed calcification of the intervertebral discs and of the articular cartilages in the wrists and knees (Figs 1, 2, & 3).

Laboratory tests were as follows: sedimentation rate 113; hemoglobin 10.7 gm/100 ml; hematocrit 33%; urinalysis negative; no LE cells; blood glucose 72 mg/100 ml; RA factor negative and the uric acid 1.4 mg/100 ml; serum calcium 8.4 mg/100 ml and phosphorus 2.4 mg/100 ml. The electrolytes were normal and several stools were guaiac negative.

A small subcutaneous mass over the left olecranon was removed. Pathologically this was a sacular structure and the cavity was filled with a recent thrombus undergoing focal organization. Chemical analysis of the phlebolith revealed calcium phosphate. Treatment was instituted with salicylates, physiotherapy, indomethacin and prednisone. He improved on this program and gradually decreased his dosage of prednisone to 5 mg daily. Aspirin and indomethacin were continued.

He was seen again in October 1968 with an acute injected with a short and long-acting steroid with good

Fig. 3—Lumbar spine. Note the calcification of the intervertebral discs.

relief. This was repeated in June 1969 for an effusion in the left knee. At various times over 35 years he was thought to have rheumatic fever, rheumatoid arthritis, chronic gout, and finally pseudogout.

Case 2. The son of the patient in Case 1 was first admitted to the hospital at age 28 in 1952. Ten weeks previously he had had a "cold" with a rash on his arms, face, and chest. A week later, he had developed pain in the right leg, thigh, hands and neck with generalized myalgias. The pains were migratory except for constant pain and swelling in the left ankle. During hospitalization he also developed severe left temporo-mandibular pain. He was a farmer and drank raw milk.

On examination his temperature was 100.2 F (orally). The hands were cold and clammy. There was an enlarged right epitrochlear node measuring 1 cm in diameter. The spleen descended 2 fingerbreadths on deep inspiration. There was increased heat with redness of the left ankle and the right knee. Laboratory tests were as follows: sedimentation rate 55; agglutination tests for brucellosis negative; hemoglobin 12.7 gm/100 ml; WBC 8,500 per cu mm; urinalysis negative; blood serology negative; spinal fluid examination normal; uric acid 4.7 mg/100 ml. Throat culture disclosed no streptococci. A lymph node was removed from the left axillary area and showed nonspecific chronic lymphadenitis. X-ray film of the chest was normal and that of the left ankle disclosed soft tissue swelling.

Initial diagnosis was brucellosis, although there was no cultural or serologic evidence of this disease. When he flare-up of arthritis in the knees. The left knee joint was

continued having difficulty with his joints, cortisone was given in a dosage of 100 mg daily. This resulted in slight improvement. However, by the end of two weeks he was able to do his farm work. Cortisone was gradually discontinued over the course of three months. He was seen periodically over the next nine years for arthralgias in most joints, usually of short duration.

In August 1961 he was seen because of a migratory type of arthritis present for two or three months. This had been particularly severe in the sternum and lower back. He was treated with phenylbutazone and improved moderately. In November 1962 he returned because of severe pain in the right knee. There was inflammation of the prepatellar bursa. Improvement resulted from rest and salicylates.

He was seen next in July 1967 complaining of migratory pains in the muscles and joints involving the back of the neck, knees, wrists, and ankles. Duration of the pain was about three hours in each joint. Treatment with phenylbutazone was only partially successful. He was given an injection of 50 mg of triamcinolone acetonide (Kenalog) intramuscularly with improvement. Two months later he was hospitalized (at age 44) with recurrent acute arthritis.

Laboratory tests were as follows: RA and LE tests negative; sedimentation rate 92; hemoglobin 9.3 gm/100 ml; hematocrit 28%; WBC 14,100 per cu mm; urinalysis negative; RA latex factor negative; calcium 9.5 mg/100 ml; phosphorus 3.0 mg/100 ml, and uric acid 5 mg/100 ml. Synovial fluid was removed from the left knee and contained 25,000 WBC and 2,000 RBC per cu mm. The synovial fluid protein was 5.2 gm/100 ml and glucose was completely absent. The mucin clot consisted of small friable masses in a slightly cloudy solution. Culture of the joint fluid was negative. The throat culture showed no significant pathogens and the ASO titer was 50 Todd units. X-ray studies of the chest and upper and lower GI tracts were normal. The left knee x-ray film showed evidence of fluid in the joint with calcification of both menisci (Fig 4).

Improvement followed the use of prednisone, phenylbutazone and aspirin. Discharge diagnosis was either rheumatoid arthritis or pseudogout. Unfortunately, the synovial fluid was not checked for the typical crystals of calcium pyrophosphate.

This patient has not been seen since October 1967. However, a report was received from another clinic in February 1968. He had negative RA tests and on one occasion had knee synovial fluid examined. No calcium pyrophosphate crystals were found. He was improving on physical therapy, rest, and salicylates. Their diagnosis was rheumatoid arthritis. In August 1968 a further report indicated that his sedimentation rate had fallen to 6 mm in one hour and there was no evidence of active synovitis. There was tenderness about the metatarsophalangeal joints but no swelling.

Discussion

Chondrocalcinosis (polyarticularis familiaris) was described in 1958 by Zitnan and Sitaj.[2] Their patients had abnormal joint calcification which involved the superficial layer of the articular hyaline cartilage and the fibrocartilage of various joints, especially the menisci of the knee. In some instances, there was also calicification of the articular capsule.

McCarty and associates[1,3,4] have more recently studied a group of 80 patients with a similar syndrome. They recognized the high incidence of an

Fig. 4—Early calcification of the joint cartilage on the left.

acute synovitis with the presence of intraleukocytic, rod-shaped, weakly positive birefringent crystals. Usually the larger joints were involved, particularly the knee joint. They described five different clinical patterns of chondrocalcinosis. Type A was characterized by intermittent attacks of acute arthritis with complete freedom from symptoms between attacks. These were similar to acute attacks of gout and were seen in 19% of their cases. Type B was seen in 7.5% of cases and showed almost continuous acute attacks involving several joints. These were mistaken for rheumatoid arthritis, although the test for rheumatoid factor was usually negative. Joint aspiration when obtained revealed the presence of calcium pyrophosphate crystals. Type C (found in 60%) showed a clinical pattern of chronic progressive arthritis with superimposed acute episodes involving particularly the large joints. Type D (14%) resembled chronic osteoarthritis without acute episodes. The fifth clinical pattern (Type E) involved only asymptomatic calcification of the joint cartilage.

Symptoms usually begin in the 40s and an individual may have one to many acute flare-ups. In the acute attack, the joint involvement usually begins slowly and reaches a peak in 24 to 48 hours. The attack may last from 12 hours to several weeks. There may be low grade fever and general malaise. There is usually a moderate leukocytosis. One or more joints may be attacked with the knee being most commonly involved. The shoulders, intervertebral discs, wrists, hips, elbows, ankles, hands, and sacroiliac joints also are afflicted. Attacks of podagra also have been described.[1] The involved joints show stiffness, swelling, and pain on movement. There may be local warmth, erythema of the overlying skin, and tenderness. McCarty and his

co-authors[1] noted that acute attacks frequently occurred after trauma, surgical procedures, and injection of mercurial diuretics.

Differentiation from an acute attack of gout may be difficult. Thirty-four percent of McCarty's patients were found to have hyperuricemia.[1] Response to colchicine has been variable[5,8] and is not as specific as that seen in cases of gout. Precise differentiation is made by the determination of the type of crystals seen in the aspirated fluid.[3] In gout the sodium uric crystals seen under compensated polarized light show a strongly negative birefringence. In contrast calcium pyrophosphate dihydrate crystals show a weakly positive birefringence. The patient with chronic recurrent and symmetrical joint involvement will require differentiation from rheumatoid arthritis. The absence of nodules, rheumatoid factor, severe soft tissue atrophy and gross deformity of joints is characteristic of pseudogout.

The cause and mechanism of calcium deposition with its propensity for involvement of the fibrocartilage are unknown. A few cases are associated with hyperparathyroidism, and in McCarty's series 40% were found to have diabetes mellitus.[1] Chondrocalcinosis also has been reported as a coincidental finding in other rheumatoid diseases, including lupus erythematosus, rheumatoid arthritis, and gouty arthritis.[6,7] Pathologically, the areas of calcification are composed of aggregates of microcrystalline calcium pyrophosphate with diameters ranging up to 0.6 cm. They may be seen on the surface of areas erroded by degenerative changes. It has been postulated that an acute attack may be precipitated by the coalescence of several deposits of calcium pyrophosphate crystals in the cartilage.[1] The resulting degeneration of the overlying tissue with rupture into the joint space produces the acute inflammation. Gout and pseudogout have been grouped together as "crystal-deposition disease," the former being due to urate crystals and the latter to deposition of calcium pyrophosphate.[1]

The familial incidence of this condition has been noted by Zitnan and Sitaj[2] with 21 of their 27 cases from five families. Moskowitz and Katz[5] have recently reported cases in two sisters, with abnormal calcifications noted in another sister and two daughters who were asymptomatic. The exact mode of transmission as yet has not been determined.

The diagnosis of pseudogout involves either the demonstration of the calcium pyrophosphate crystals or monoclinic and triclinic crystals showing a weakly positive birefringence in joint fluid along with typical cartilage calcifications on the x-ray films. A *probable* diagnosis would involve either the identification of the above noted crystals or the typical cartilage calcification. One should consider this disease in the presence of acute or chronic arthritis of the knees or other large joints. Both of our patients had typical calcification in the knee joints and in the case of the father calcification was noted also in the lumbar intervertebral discs and in the fibrocartilage of the wrists. The father had a biopsy of the elbow joint with chemical analysis disclosing the presence of calcium phosphate.

Acute attacks of pseudogout sometimes respond to aspiration of the joint fluid.[8] The addition of intra-articular steroid is often beneficial, according to previous reports and in one of our patients.[1,5,8] The beneficial effect of colchicine has been equivocal.[1] Certainly the response is much less definite than in cases of early acute gout. Systemic corticosteroids, salicylates, and phenylbutazone are variably helpful.[1,5,8] In one of our patients indomethacin was apparently effective.

Summary

Chondrocalcinosis, probably as a result of pseudogout, has been observed in a father and son. Both have recurrent acute and subacute arthritis of major joints with calcification of fibrocartilage in the knees. The father had similar calcification in the wrists and intervertebral discs. Uric acid determinations were normal and the RA factor tests were negative in both. The arthritis responded temporarily to intra-articular or systemic corticosteroids and at times to physiotherapy, salicylates, indomethacin, and phenylbutazone. The familial occurrence has been previously reported.

This syndrome should be considered when one sees a patient with acute, subacute, or chronic arthritis of major joints with normal uric acid, negative RA factor, and calcification of intra-articular cartilage. The synovial fluid should be examined for the presence of calcium pyrophosphate crystals to confirm the diagnosis.

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L-Dopa and Amantadine in the Therapy of Parkinsonism

GUNNAR GUNDERSEN
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La Crosse, Wisconsin

■ *Dr. Gunnar Gundersen, with his medical family and colleagues, has supported and witnessed a phenomenal growth of group-practice clinics in Wisconsin. We are happy to be a part of this growth.*

JOHN B. WEETH, M.D., F.A.C.P.
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ENCOURAGED BY THE initial report of L-dopa (levodihydroxyphenylalanine) therapy of parkinsonism by Cotzias *et al*,[1] in 1967, we wanted to obtain the benefits of such therapy for our patients here. The rationale of L-dopa therapy is discussed by Cotzias in his paper. In October 1968 TIME[2] and LIFE[3] magazines publicized L-dopa therapy of parkinsonism. The word "cure" was not used, but the public has been conditioned to think in terms of "cure" and "breakthrough." At our clinic there was anxious inquiry from families and patients as to when "L-dopa would be cleared by the FDA."

In December 1968, we submitted our qualifications to the Food and Drug Administration (FDA) for a license to conduct clinical trials of L-dopa. One of us (JBW) is an investigator in cancer chemotherapy for the National Institutes of Health (NIH). His clinical pharmacologic background is particularly well suited for a project with potentially hazardous drugs. The other physician of the investigating team (CNS) is a neurosurgeon who is familiar with parkinsonism clinically and in research laboratory. The license was issued promptly and our first clinical trials began Feb. 5, 1969, based on the published information supplied by Cotzias *et al.* In late April our dosage increments were speeded up after reviewing unpublished information provided by Plum[4] on more than 100 patients treated with L-dopa for over six months, with a wider base of nearly 200 patients managed. Our modifications were not specific recommendations by Doctor Plum but rather adaptations we chose to make after reviewing his information.

The parkinsonism therapy project was added to already busy medical and neurosurgical practices with on-call nights and similar responsibilities. We have no research funds to cover either patient or research expenses.

In the May 19, 1969, issue of the JAMA, Schwab *et al*[5] announced the fortuitous observation of the beneficial effects on parkinsonism of amantadine hydrochloride (Symmetrel). Since this medication could be bought by prescription and the maximum daily dose was only two capsules (instead of possibly ten or more L-dopa capsules), we elected to start most patients on this therapy and reserve L-dopa for those with inadequate responses to amantadine.

A readily available second new medication made it difficult to adhere to previously planned protocol schedules. Our experiences with the effects and results of therapy were rather different from what we were expecting and required many alterations in plan of care. Patient functional status, social factors, economic problems, and geographic location also have had profound effects on each patient's treatment program. Our results present a confusing picture, but we suggest this is our major point: This is how it will be "when the FDA clears L-dopa!"

Acceptance of even a single patient for therapy of parkinsonism is a major project. We have had to have the help of our Social Service Department and clinic administrators. We limit admission of patients to hospital units where nurses are familiar with L-dopa and parkinsonism. A specially assigned licensed practical nurse (DM) was necessary to eval-

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uate and catalog patient responses in consistent fashion. We believe that special Parkinson evaluation forms will continue to be important for optimum patient care even when no longer needed as part of Investigational New Drug (IND) requirements.

Magazine, newspaper articles, and word of mouth bring in Parkinson patients and their families seeking treatment. The lay press articles have complicated considerably the problem for us. As just one example, the July 1969 LADIES HOME JOURNAL[6] reported L-dopa as "the spectacularly successful experimental drug against Parkinson's disease." New patients and their families are nearly beside themselves with anxiety lest any last minute slipup keep them from taking the wonder drug. They are faced with inability to work and frantic to be freed from rigidity, tremor, and invalidism. Long-suffering families envision release from perpetual care of invalids too sick to do for themselves but too well to die.

Some become visibly upset at suggestions of using any medication other than L-dopa. Others are angered as they learn it will not be one short course of treatment but rather that they are faced with financing perpetual medication costs. While most have been very patient waiting for beneficial effects to appear, it has been a bitter blow to those who have not been helped. Patients and family despondent over unsightly tremor have been especially disappointed. Suppressed fears about "side effects" quickly surface if beneficial results do not appear soon.

After initial good results with our first two patients, in keeping with the "advance press notices" of L-dopa, the magic seemed to wear off. We were beginning to wonder what was wrong and to doubt the potency of our drug supply. It was, therefore, very informative to read a study published in April 1969 which was called to our attention by an editorial in the Sept. 1, 1969, issue of the JAMA.[7] Calne *et al*[8] in England reported results somewhat like ours. They treated patients hospitalized for an average of 29 years, all with a history of illness in the encephalitis pandemic of 1916–1926. In the double-blind study, 20 people received L-dopa for seven weeks. "Seven improved substantially and 3 moderately; 5 showed no useful response, and 5 had to stop L-dopa because of adverse effects."

Our results do not lend themselves to neat, tabular summaries. We present all of our 65 patients, however. Nine patients were treated with L-dopa alone. Two patients had shunt procedures as well. Fifteen patients had combination therapy with amantadine and L-dopa and 39 patients have been treated with amantadine alone.

Surgical–Medical Therapy

Two parkinsonian patients with mental deterioration were found to have internal hydrocephalus, and ventriculojugular shunts were done. When they showed initial lack of response to surgery, L-dopa was started. Each has received 3.0 gm daily for over four months. The 79-year-old lady is no longer mute and is improving mentally but has little muscle improvement. The 77-year-old man is improving mentally and in mobility as well. The role of L-dopa can only be shown by stopping its use, but we are not yet willing to try this.

L-Dopa Only

The nine patients who have been on L-dopa therapy alone present examples of our experiences with the entire program.

Our first study patient is a 53-year-old vivacious lady who had become unable to teach at college. She was virtually bedridden and barely able to walk with a cane. She has ochronosis with its accompanying cartilaginous calcific arthritis. Theoretically L-dopa might have aggravated her arthritis because it increased excretion of homogentisic acid. Her desperate situation, however, convinced us that trial of therapy was indicated. Having returned to full activity, she represents the one "miracle" result in our series. She thoroughly enjoys the "healed leper" role and has been responsible for a number of referrals to our clinic.

The second study patient is a 43-year-old insurance salesman who was on the brink of having to stop work. His moderate rigidity and slurred speech were ruining business. At 4.5 gm per day he is back to work full-time, tiring only slightly easily. The lady tried amantadine one week, felt a little jittery, and stopped it lest her excellent results be impaired. The man didn't want to try amantadine at all for the same reason.

Three patients have shown slight but useful improvement. A 71-year-old lady can only tolerate 750 mg daily. The major improvement has been wheel-chair-to-cane status. Her tremor is still marked. The other patients have been taking 0.5 gm daily as outpatients for a little over a month. The initial evaluation has been encouraging.

A 70-year-old man requested transfer to our clinic to avoid the 250-mile trip to another city. He came to us with a history of steady increasing activity on 5.0 gm daily for two months with levodopa, Eaton. He was switched to levodopa, Nutritional Biochemicals, for five weeks and his improvement has continued. All of our other reported patients have been treated with levodopa, Nutritional Biochemicals. We are now using supplies from both manufacturers. Levodopa, Roche, is not presently available to us. All three sources indicate limited supplies.

Three of these nine patients have had adverse neurologic problems during L-dopa therapy. A 76-year-old man was worked up to a daily dose of 3 gm in 21 days with evidence of initial improvement. On the 48th day he became confused, restless, and could not walk. Levodopa was stopped. It may be cautiously restarted later. A 57-year-old lady with troublesome mouth movements was improved after

one month on 2.0 gm daily. Then severe involuntary mouth jerks began. Dosage was reduced to 1.0 gm daily and the jerking stopped. When seen later, she was drooling badly and significant mental depression was evident. Addition of benztropine mesylate (Cogentin) has helped greatly. A 52-year-old lady had leg twitches on a daily dose of 3.0 gm but has shown overall improvement for three months when dosage was reduced to 1.5 gm daily.

L-Dopa Plus Amantadine

The 15 patients who have had combination therapy are not easy to tabulate! They exhibit eight different types of responses which merit reporting.

(1) *Amantadine addition no help:* A 64-year-old man showed steady improvement in function on maintenance L-dopa of 3.0 gm daily. Amantadine was stopped when its addition for one month had no discernable effect.

(2) *Improved on combination:* A 71-year-old man improved steadily on 200 mg of amantadine and 1.5 gm of L-dopa daily. His stomach could not tolerate a higher dose of L-dopa. He understandably doesn't want to alter either medication.

(3) *Unable to tolerate combination:* Four patients have had adverse results when L-dopa and amantadine were combined. One (72M) was showing improvement on 1.5 gm daily of L-dopa (maximum gastrointestinal tolerance). When amantadine was added, mouth jerks occurred after nine weeks. He hasn't done as well since. A second patient (73M) showed no benefit from amantadine alone and became agitated when L-dopa reached 2.5 gm daily. He is doing better with 1.0 gm daily. A third patient (71F) has been able to return to her music playing on 1.5 gm daily of L-dopa, but the amantadine was stopped when she reported seeing "pleasant" ghosts and flying hair nets. The fourth patient in this group was a 65-year-old lady who had lessened rigidity on L-dopa, 3.0 gm daily. When amantadine was added, pretherapy tendencies to shriek were aggravated and she was a difficult nursing problem. She was calmed with 60 mg of sodium amobarbital (Amytal) orally and 50 mg of thioridazine hydrochloride (Mellaril), each four times daily. When general muscle stiffening returned following cessation of L-dopa, the daily dose of 3.0 gm was restarted. She has gradually improved to the point where she was returned improved to her former nursing home. She shrieked when she wanted her television channel changed. What a problem in a general hospital setting! An attempt was made just prior to transfer to diminish the Mellaril but decreasing from 200 to 150 mg per day was followed promptly by noticeable restlessness and the 200 mg was immediately resumed. This patient illustrates the complex pharmacologic, nursing, and time problems of treating the severely afflicted.

(4) *Unable to tolerate amantadine alone:* One patient had nausea and the other felt poorly so amantadine was stopped. They have shown benefit from L-dopa.

(5) *Intolerance to both:* A 69-year-old man hasn't seemed to be able to tolerate either medication without vertigo. Although an effective executive, he does have a history of a brain injury. He keeps trying.

(6) *No miracle cure:* Three parkinsonian patients with pronounced pretherapy psychonuerotic problems declare they worsen with either or both drugs.

(7) *Treatment failures:* Two patients have died. A 65-year-old lady failed to respond to 4.5 gm of levodopa and 200 mg of amantadine and died in a nursing home of aspiration pneumonia. A 66-year-old man had peculiar mute and dysphagic spells prior to therapy. Worried lest he die of aspiration before having an opportunity to be treated, we started levodopa. During five months he was taking usually 4.0 gm daily. He didn't like the addition of the amantadine. He gradually became much less rigid. During this time he injured his back seriously and sustained compression fractures of thoracic vertebral bodies. He had one episode of aspiration pneumonia. His back began to hurt more and his condition deteriorated into occasional mute episodes, and levodopa therapy was stopped prior to death, when he was reported agitated at night. Nursing and geographic factors were problems. He died, apparently of aspiration, in his local hospital.

(8) *Serious aggravation of parkinsonism:* A 47-year-old man has been incapacitated since World War II. He was started on amantadine in the nursing home where he lives and showed modest brightening. Hospitalized for addition of levodopa, previous mental derangements seriously worsened. Sustained shrieking episodes occurred with administration of 1.5 gm of levodopa plus the usual 200 mg of amantadine daily. Both therapies were stopped. Then he had an aspiration pneumonia. He survived this and responded again to amantadine alone. He returned to the nursing home with the modest amantadine improvement, which is since fading.

Amantadine Alone

Results with 39 patients treated with amantadine alone can be summarized more easily. One patient, chairbound and mute, improved markedly and is active, up, and alert in sustained fashion for three months thus far. Seven patients improved from chairbound to walking. One did not attain improvement until trihexyphenidyl hydrochloride (Artane) was restarted. Two have sagged from their initial improvement. Sixteen patients have shown useful improvement to a lesser degree. Three of these have sagged some and one patient had to stop amantadine because of nausea. Seven patients have not yet returned for initial evaluation. One of these is overdue. Six patients showed no change.

Adverse results from amantadine are not emphasized in the above summary but they definitely

occurred. Some have been reported in the combination amantadine–levodopa group. One patient required lowering of Artane. In keeping with our interpretation of Schwab's report, our initial therapeutic maneuver was to decrease patients' maintenance doses of Artane, Cogentin, and the like to the minimum tolerated dose or to no medication at all. This alone caused much difficulty for the patients and resulted in numerous phone calls. We now prefer to leave patients on their present stable programs and cautiously add amantadine, 100 mg daily, for a week or two and then increase to 200 mg if tolerated. In this way only one variable factor, the amantadine addition, is introduced.

Impressions

(1) L-dopa has indeed been beneficial for some patients. We agree particularly with Calne *et al*[8] that the most notable improvement has been in control of walking. We also have found maximum tolerated daily maintenance doses of 0.5 to 4.0 gm of L-dopa rather than the higher ranges found by Cotzias.

(2) Amantadine therapy alone has been beneficial. It seems definitely worth trying first if only on a cost, simplicity, and availability basis.

(3) We have not seen organ toxicity such as marrow, cardiac, liver or renal function impairment from either agent.

(4) We regret the absence of organized information reaching us in the use of these new medications. In the National Cancer Institute Cooperative Chemotherapy Programs, all investigators are notified if anyone reports a previously unknown serious problem with any of the medications being investigated. All are supplied with quarterly computer summaries of all studies to date. No organized distribution of pooled data exists for investigational therapy with L-dopa. For instance, at this late date, the Sept. 5, 1969, MEDICAL NEWSLETTER[9] reports "cardiac arrhythmia has been an occasional troublesome complication." Information such as this should reach all investigators without delay rather than our having to learn of this through chance reading of medical periodicals.

(5) Worsening of parkinsonism and adverse neurologic results may appear with little warning on any medication program we have used.

(6) Patients often do poorly when standard anti-Parkinson therapy with Artane, Cogentin and the like are decreased substantially or stopped. We believe in some instances the final effect of this decrease may not be evident for many days, making it difficult to assess whether an undesirable change in the patient's condition is due to withdrawal of the previous drug or cumulative effect of a newly added medication.

(7) The postencephalitic, arteriosclerotic, and idiopathic classification of parkinsonism seems inadequate. The varied pictures of patient condition and response suggest this.

(8) Pneumoencephalograms have suggested that occult internal hydrocephalus and cerebral atrophy can be factors in the total patient problem and deserve consideration in the therapy program.

(9) We caution would-be healers of parkinsonism that the requirements of physician time and energy can be prodigous. Our present group of patients has left us no time for new patients just now.

Comment

The "awakening" and "stimulating" effects of these medications justify exciting speculation. Our crowded planet does not need humans with life spans of 150 years; but if we are able to be more alert and active while we are here, it would be a distinct advantage for man. A few improvements in seemingly "senile" parkinsonian patients has made the entire effort rewarding. Anything is worthwhile which holds out hope of freeing humans from the prison of "chronic brain syndrome" and physical enfeeblement in any way. Nevertheless, as with most "miracle" drugs, preliminary reports and lay press articles have been excessively optimistic. L-dopa and/or amantadine offer slight to significant improvement in 25% to 40% of patients. Undoubtedly future generations of medications will significantly improve this percentage.

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NEW RESEARCH . . .

Carbenicillin: Elicited clinical cures in 12 of 22 patients (54%) with serious Pseudomonas infections, including 4 of 8 with pneumonia, 1 of 4 with bronchitis, 2 of 3 with pyelonephritis, and 5 of 7 with skin/soft tissue infections. The drug is an experimental semi-synthetic penicillin. By Drs. Robert L. Perkins, H. N. Carlisle, and S. Saslaw, Ohio State U College of Medicine, Columbus.—Reprinted from AMERICAN DRUGGIST, June 30, 1969 □

California Virus (La Crosse Strain) Encephalitis

By STEPHEN C. COPPS, M.D.
and A. C. V. ELSTON, M.D.
La Crosse, Wisconsin

■ *Ever since I've known Gunnar I've looked upon the man with a great deal of respect and admiration. On my first visit to the clinic several years ago, I was immediately taken by his erect carriage and ready smile; his insatiable curiosity and willingness to share his many varied and marvelous experiences with others. He is indeed a leader, and as such has contributed so much of his distinguished character to his clinic and to American medicine.*

STEPHEN CLINTON COPPS, M.D.

CALIFORNIA VIRUS INFECTION is now recognized as the commonest arthropod (mosquito)-borne encephalitis in Wisconsin.[1] It is an infectious central nervous system disease occurring in summer and early fall. Males, more often than females, are afflicted, and symptomatic disease is rare in adults. Although convulsions are common during the acute illness, the permanent neurological sequelae incidence is low.[2,3]

Hospital Experience

In September 1960, a four-year-old girl died at our hospital of an overwhelming, presumed viral, encephalitis. Specimens of brain and spinal cord tissue were sent to the State Laboratory of Hygiene in Madison for attempts at viral isolation. Routine procedures failed to yield results but four years later, after finding serological evidence of California virus infection in Wisconsin, Wayne Thompson of the Department of Preventive Medicine restudied the material which had been stored at —40 C and was able to obtain the first isolate of California virus from a fatal human case.[4,5] This isolate has been used to make improved antigen for serological testing and has been identified as the La Crosse strain of the California group of viruses. This strain is, to date, the only strain of the California group of viruses associated with clinical human illness in Wisconsin.

Reviewing sera that we sent for antibody study that same year resulted in the eventual diagnosis of two more cases. No cases were detected here during the following two years (1961–1962) but in the five-year period, 1963 through 1968, 19 proven cases have been cared for in our hospital as well as seven presumptive cases which demonstrated less than a fourfold, but greater than a twofold, rise in antibody titer. The presumptive cases clinically resemble the proven cases.

During this same five-year period, 83 hospitalized patients were considered to have viral encephalitis. Of these patients, California Virus Encephalitis (CVE) was the commonest encephalitis seen. Twenty-six patients had proven or presumptive CVE, 13 had mumps encephalitis (not a true reflection of mumps encephalitis incidence for many patients with suspected mumps encephalitis were not hospitalized), 4 had measles, 4 influenza, 3 ECHO virus, 2 Coxsackie, 1 chickenpox, and 1 herpes. In 29 (35%) of the cases, a viral etiology could not be firmly established. In comparing the hospital incidence of viral infectious CNS disease (83 patients) to bacterial disease during this five-year period, 42 cases of bacterial meningitis were treated.

Clinical Picture of California Virus Encephalitis

Of the 19 patients with proven CVE, 13 were males. They ranged in age from 16 months to 11 years, the average being 6 years. Three were admitted in July, 4 in August, 9 in September, and 2 the first week in October. All lived in rural or wooded suburban areas within a 70-mile radius of La Crosse.

All children old enough to give a history complained of headache, usually frontal. All except two had episodes of vomiting. There appears to be a wide range in the severity of signs and symptoms of the disease, for several experienced a relatively insidious onset with headache, vomiting and fever lasting two to four days before hospitalization, while a few had an explosive onset with convulsions occurring a few hours after their first symptoms. Fever ranged from 101.4 F to 105.2 F, usually reaching its maximum three to four days after the onset of symptoms and falling, by lysis, until its disappearance seven to nine days after the illness began. Seven of the 19 patients had convulsions. Five had generalized grand mal seizures while 2 had localized seizures. In one of the patients who had convulsions, there was a history of a febrile seizure as an infant. Unlike Western Equine Encephalitis in which the

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younger child is more apt to convulse, there appeared to be no association between the age of the child and the presence of convulsions. All appeared to have various degrees of lethargy, but there were no frank comas except for relatively short postictal periods of unconsciousness. A transient unilateral paresis was noted in one of the children with localized seizures, but other than that, no significant muscle weakness could be demonstrated. Apart from the sensorial changes there appeared to be a paucity of neurological findings in most patients. Four had depressed superficial abdominal reflexes. Two had depressed deep tendon reflexes, while in 2 others it was felt that the DTRs were hyperactive. Three of the 7 patients who had one or more seizures had transient unilateral or bilateral Babinskis. Of the 7 patients who had seizures, 4 had only one, 2 had two seizures and 1 child had four. Almost all patients, during their illness, demonstrated some degree of mental confusion. Frank delirium was present in 5. None complained of diplopia or photophobia.

Peripheral white blood counts at the time of admission were elevated and usually quite high with a predominance of polymorphonuclear forms. Another example of the fallacy of assuming a bacterial etiology for infectious disease on the basis of leukocytosis with a high percentage of polys. White blood cell counts ranged from 11,400 to 29,300 per cu mm with an average of 18,300. Polymorphs averaged 80% of the white cells on smear. Erythrocyte sedimentation rates done on 9 of the 19 patients ranged from 28 to 74. C-reactive protein was negative in all 7 cases in which this test was perfomed.

Four of the 19 with proven CVE failed to reveal signs of meningeal irritation (nuchal and/or lumbar rigidity). Lumbar punctures were performed on these patients primarily because of the combination of severe headache and vomiting in febrile patients without an etiologic diagnosis within 36 to 48 hours after admission. One patient who had a rather severe convulsive episode did not have neck stiffness. The tap in this child was done because of the seizure. All initial cerebrospinal fluid examinations revealed a pleocytosis without demonstrable evidence of a bacterial etiology on smear. CSF cell counts ranged from 10 to 971 with an average of 160. Lymphocytes were predominant in all cases except one which had a 56% poly differential. There were no significant protein elevations and all CSF sugars were normal.

With but a few exceptions, the course of the disease was relatively benign, the patients feeling quite well by the time their temperature returned to normal seven to nine days after the onset of symptoms. One patient had severe recurrent episodes of vomiting for almost three weeks while another had a series of four grand mal seizures during the first three days in the hospital. Both these patients, as well as all the others, appeared to be entirely well on post-hospital clinic visits one to two weeks after discharge.

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None of the patients who had seizures during their acute illness has had seizures since discharge. These patients have now been followed for from ten months to five years. Reports on the electroencephalographic abnormalities during the acute phase of the illness, neurological examination and EEG followup, and psychometric test followup of patients with CVE (including 14 of our cases) have been previously published. In general, the incidence of persistent neurological and/or psychometric deficit has been low but some patients (12% in Dr. Chun's series) have had seizures after their acute illness.

In order to make a diagnosis of CVE, it is necessary to demonstrate a fourfold or greater rise in antibody titer. Serum should be obtained during the acute phase of the illness, and a convalescent serum approximately three weeks later. In addition to the serum specimens, it is advisable to send stool specimens and spinal fluid for attempts at virus isolation. The specimens should be sent to the State Laboratory of Hygiene in Madison with a request for encephalitis virus antibody and isolation studies. Mailing containers can be obtained from the State Laboratory.* It is certainly recommended that all patients with suspected viral encephalitis have antibody and isolation studies in order that the true etiology and incidence of the disease might become better understood.

Distribution and Epidemiology

It is now known that the virus is present throughout the state, for antibody titer has been demonstrated in serum obtained from wildlife workers in most counties, especially those in northern, central, and western Wisconsin. The fact that most clinical cases of CVE have been reported from our area may be because of our awareness of the disease, resulting in a more concentrated effort to get paired serum specimens to the State Laboratory for antibody study. In 1965 there were 14 cases of proven CVE in Wisconsin; 6 (almost half) were hospitalized here. During the same year there was only 1 case of Western Equine and no cases of St. Louis or Eastern Equine encephalitis in our state.

* State Laboratory of Hygiene, University of Wisconsin Medical Center, Madison, Wis. 53706.

Awareness of the possibility of CVE is undoubtedly not the entire answer to the higher incidence of clinical disease in southwestern Wisconsin, for certainly conditions here are favorable for the breeding and propagation of the tree-hole mosquito *(Aedes triseriatis),* the apparent vector. These mosquitoes prefer humid, forested areas.

Isolation of the virus from small mammals suggests that these animals serve as the natural host for the virus, with mosquito vectors transmitting the virus from animal to animal and from animal to man. Human-to-human transmission has not been demonstrated.

An interesting facet of the study of CVE is the fact that for all practical purposes, only children are afflicted. Of the approximately 60 cases of CVE reported in Wisconsin since 1960, only 1 has been an adult (a young man in his mid-20s). Only 7 have been teenagers. It is perhaps possible that the inapparent disease rate is so high that antibody protection is present in most adults. This may be accompanied by a natural tissue immunity to neurotropic viruses that increases with age.

Summary

California virus encephalitis, an acute viral central nervous system disease, is prevalent in Wisconsin. The disease usually occurs in children and has only been reported during July through early October. There is a wide spectrum of manifestations of the disease, from inapparent illness demonstrated only by antibody titer to a few fatal cases. As with other arthropod-borne encephalitis, the disease is characterized by severe headache, nausea and vomiting, mental confusion, and lethargy. Convulsions are common during the acute illness but complete recovery without demonstrable sequelae is the general rule. Diagnosis is established by demonstrating a fourfold or greater rise in antibody titer.

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CONGENITAL AND FAMILIAL IRON OVERLOAD

L. VITALE, MD, J. M. OPITZ, MD, and N. T. SHAHIDI, MD, University of Wisconsin Medical School, Madison, Wis.: **New Eng J Med** 280:642–645 (Mar 20) 1969

Increased concentration of iron in the body is an acquired condition. The newborn infant is endowed with a body iron concentration of approximately 75 mg/kg. The reasons for this fairly constant concentration of iron are not known. It is thought that both fetus and placenta play a role. Recently a full-term newborn infant presented with hypotonia and other minor congenital anomalies. The patient died at the age of two months from bronchopneumonia. Post mortem examination revealed brain abnormalities (paleocerebellar hypoplasia and micropolygyria), polycystic kidney and significant hemosiderin deposits in the liver.

A year later, the mother delivered another full-term infant with similar findings. Both parents were healthy with a normal hemogram and serum iron. Because of marked hypotonia and poor sucking the infant was kept in the hospital and was fed milk alone by gavage. At two months of age a liver biopsy was performed and revealed heavy deposits of hemosiderin which was also present in significant amount in the macrophages of the bone marrow. Serum iron then determined was found to be 270 μg% (normal 55–110 μg%) with a TIBC of 284 μg%.

There was no anemia or evidence of hemolysis. Red cell mass by $Cr.^{51}$ was 31.6 ml/kg. Post mortem examination at five months of age revealed kidney and brain abnormalities similar to those found in the sibling. Significant hemosiderin deposit was found in the liver, spleen, kidney, and pancreas. Chemical analysis confirmed the excess of iron in these tissues in showing more than a 3-fold increase iron in the liver and 10-fold increase iron in the kidney. The above findings suggest a genetically determined error of regulation of iron transport in utero resulting in such a unique and heretofore unrecognized condition. □

DIABETES DETECTION

During 1968 there were 249 new diabetics discovered in Duval County, Florida (Jacksonville) as a result of an ongoing Why Wait? diabetes detection program. Total number of persons screened was 9,562; of these there were 504 primary positives and 391 secondary positives.

The program uses capillary blood sugar Dextrostix readings of 200 mg% at one hour, 150 mg% at two hours and 130 mg% at three hours. Program sponsors are the Duval County Lay Diabetic Society and the Duval County Department of Health.—*Disease Detection Newsletter, Vol. 2, No. 3 (August 1969)* □

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Severe Soft Tissue Avulsion Injury to the Lower Extremity with Circumferential Skin Loss

Report of Two Cases in Children with Successful Rehabilitation

By A. ERIK GUNDERSEN, M.D., F.A.C.S.
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A CRUSHING, SHEARING FORCE when applied to the extremity may result in total skin and subcutaneous tissue loss over the circumference of the limb. This is frequently combined with fracture and also exposure of periosteally denuded bone. The injury requires a maximum of surgical and orthopedic attention to accomplish soft-tissue coverage, bone healing and limb rehabilitation. This problem has been discussed in previous papers.[1,2] Recent experience with two such cases occurring in children has caused us to review the salient points of management.

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Case Reports

Case 1. A 15-year-old boy was involved in a bicycle-truck accident Aug. 24, 1967, at which time the dual wheels of the truck ran over the victim's legs. He was brought to the hospital emergency ward shortly afterward. His major injury was confined to his lower extremities. On the right there was an avulsion-laceration injury of skin and subcutaneous tissue involving the circumference of the leg from the knee to the ankle. On the left there was a similar avulsion-laceration injury that involved only the medial knee area. Both lacerations were grossly dirty. All pulses, tendons, and nerves were intact bilaterally. X-ray films showed a helical fracture of the distal left femur (Fig 1).

The patient was operated upon under general anesthesia after immediate supportive measures. On the right it was discovered that the skin and subcutaneous tissues of the lower leg could be pulled down inside out like a knee sock to the malleoli at the ankle. No skin had been lost and there was no absolutely devitalized skin. The injury was cleansed, irrigated, and the skin flaps were sutured back into place. Hemovac catheters were left beneath the flaps. The leg was left open, no dressing applied, and rested on Telfa plastic sheeting. On the left the wound was into the knee joint, with the same avulsion of skin and fat over the medial knee area but without skin loss. This side was cleansed, irrigated, and the skin flaps sutured into place. A Steinman pin was placed into the tibial tubercle. Postoperatively this leg was placed in balanced suspension traction.

During the first postoperative week the skin of the right leg blistered, discolored, and demarcated. On the seventh day following admission general anesthesia again was administered. All necrotic skin and subcutaneous tissue was excised from both legs. This included the entire circumference of the right leg, knee to 4 cm above the malleoli, and a patch 15 x 15 cm from the medial left knee. An area of right tibia approximately 4 x 2 cm size was left completely exposed, denuded of all covering including periosteum. Again the right leg was left open, resting on Telfa plastic sheeting (Fig 2).

Following this debridement the exposed tissues of both legs were treated with topically applied polymyxin, neomycin and chloramphenicol (Chloromycetin) solution. This was dabbed on with cotton swabs and irrigated with asepto syringes every two hours. After several days of this topical therapy during which time Pseudomonas organisms were cultured from the wound surfaces, split-thickness skin grafting was undertaken. Thirteen days after admission, split-thickness grafts were applied to all the open surfaces from thigh donor sites. Multiple drill holes were placed in the exposed tibia to stimulate granulation tissue growth from the marrow cavity.

The left-leg recipient sites were left exposed; but because of the contact of the right leg with the bed, this circumferential graft was enclosed in soft dressings. All topical therapy was stopped, but systemic antibiotics consisting of penicillin, 20 million units per day intravenously; kanamycin, 1.0 gm per day intramuscularly; and colistin (Coly-Mycin), 250 mg per day intramuscularly, were administered.

The first dressing was performed on the fourth day after grafting. The graft take was approximately 90%. Areas of sepsis were debrided and the leg left open once again for topical therapy.

Fig. 1—Case 1: Initial injury; photo taken in hospital emergency room.

Fig. 2—Case 1: Right leg, necrotic skin and fat removed.

A second skin grafting was performed a week after the first at which time a thorough washing and debridement were done followed by placement of grafts which had been refrigerated since the first grafting procedure.

Following this the boy proceeded to heal satisfactorily, filling in small defects and maturing the new grafts including those refrigerated. Twice daily hexachlorophene (pHisoHex) washing of the grafted surfaces was begun five days later, and after two days he was able to flex the right knee to 90 degrees and to demonstrate good mobility of the right ankle (Fig 3).

One month following the accident there was complete skin coverage of both leg soft tissue wounds; the only coverage problem remaining was the exposed tibia.

The K-wire was removed from the left leg six weeks following the injury. Ambulation was begun two and one-half months post-injury. Despite full weight bearing on the right leg, no serious swelling of the foot occurred. In an-

Fig. 3—Case 1: Skin grafting completed; coverage complete.

ticipation of swelling with increased ambulation, special elastic stockings were fitted for the right foot and left lower leg.

He was discharged three months post-injury, with partial weight bearing on the fractured leg, full weight bearing on the right leg. Granulation tissue could be seen growing onto the exposed bone from the edges and from the previously placed drill holes (Fig 4).

Six days after discharge the sequestered tibia separated from the granulation tissue bed. This open area then went on to epithelialize itself and closed spontaneously.

Subsequently the patient became ambulatory. He has had some residual problem with a keloid cicatrix of the left popliteal area. This was excised, and split-thickness grafts were applied in May 1968 with good result. At present he has some residual problem with keloid scars and does wear an elastic support for the right foot and left lower leg.

He complains of some residual aching and swelling and his activities will have to be guarded to avoid injury (Fig 5).

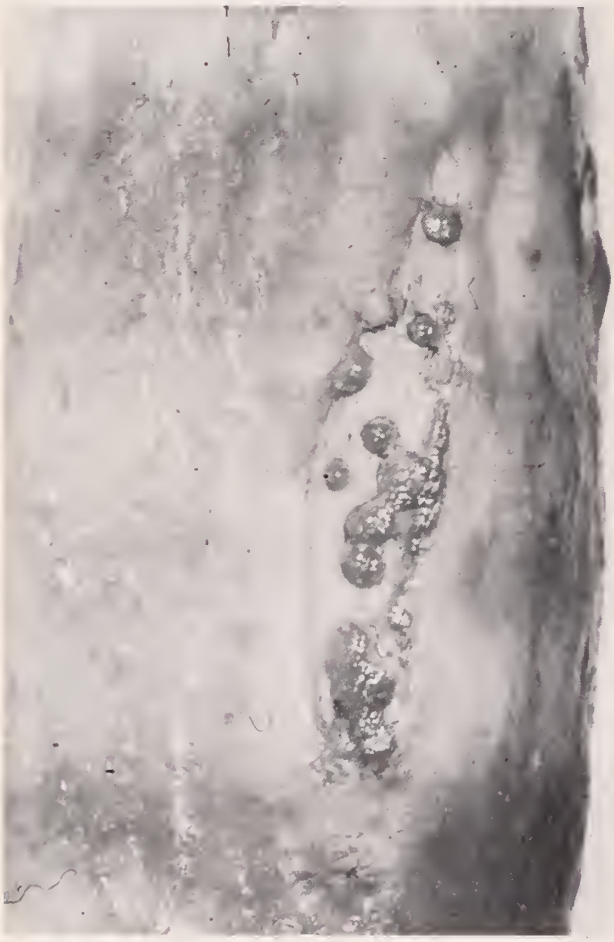

Fig. 4—Case 1: Granulation tissue appearing from drill holes seven weeks following injury.

Fig. 5—Case 1: Final result four months following injury.

Fig. 6—Case 2: Initial injury; photo taken in hospital emergency room.

Case 2. An 8-year-old boy was riding on a hay conditioner Aug. 14, 1968, when his right leg became engaged in the machine and received extensive injury before the machine could be stopped and his leg disengaged. He was admitted to the hospital emergency ward one hour following injury. There was an avulsion-laceration injury of the skin and subcutaneous tissue of the lower leg from knee to ankle involving the entire circumference of the limb. There were also exposed comminuted fractures of mid-tibia and fibula (Fig 6). The circulation of the foot was

Fig. 7—Case 2: Right leg, skin grafts applied.

Fig. 8—Case 2: Right leg, skin grafts applied.

Fig. 9—Case 2: Skin coverage of leg complete; tibia exposed; new sequestrum in photo.

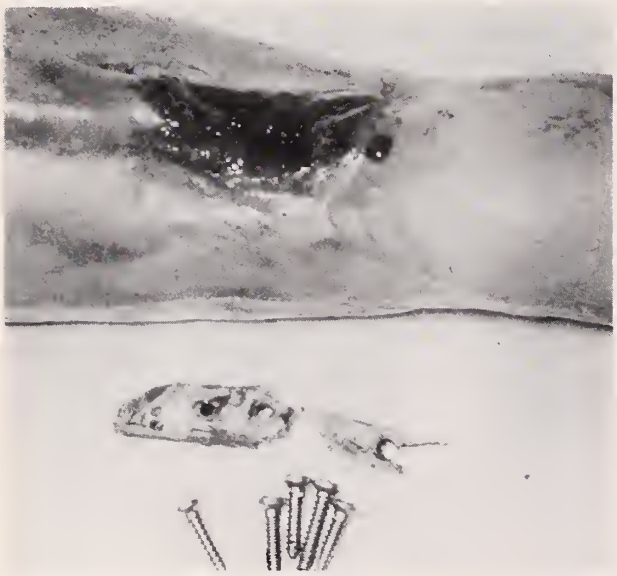

Fig. 10—Case 2: Sequestered tibia and screws removed.

poor; pedal pulses could not be felt. With the usual supportive treatment he was given general anesthesia and operated upon within 30 minutes of admission.

At operation the avulsion of the skin and subcutaneous tissue was found to be complete, from mid-thigh to below both malleoli with additional muscle laceration of the medial gastrocnemius. The posterior tibial artery and nerve were exposed, the artery pulseless. The wound was cleansed, irrigated, and debrided. The tibial fracture was fixed with five Vitallium screws. The posterior tibial artery was opened through a transverse incision. Arterial bleeding was present but minimal. No clot was found upon exploration proximally with a Fogarty catheter. It appeared the artery was partially occluded by severe spasm. Closure was performed with several 7–0 interrupted silk sutures. The avulsed skin with attachments both above the knee and below the ankle was sutured into place recovering the entire lower leg. A Kirschner wire was placed through the distal femur and one through the calcaneus. The leg was suspended by overhead traction. Dressings were applied.

Dressings were removed under general anesthesia on the second day following admission. Several necrotic areas were debrided. Topical application and irrigation with polymyxin-neomycin-bacitracin solution was begun every two hours. A second debridement under general anesthesia was performed three days later. This time the entire circumference of skin and subcutaneous fat from the distal thigh to below the malleoli was found necrotic and was removed. Purulent material was found in the planes between the calf muscles and posterior to the tibia. Drains were inserted. The fracture sites were completely exposed; the tibia was denuded of periosteum over an 8 x 3 cm area. Topical application of antibiotic solution was continued around the clock.

Skin grafting of the entire exposed wound was undertaken eight days post-injury, and three days following the major tissue excision. The left leg was used as donor site; grafts were applied without suturing and the entire area left exposed postoperatively. These grafts took to an estimated 75%. The wound surfaces grew *Aerobacter aerogenes,* sensitive to ampicillin which was administered orally. Topical antibiotics were not used following grafting.

A second split-thickness grafting was carried out seven days following the initial grafting procedure. This time donor sites were abdomen, chest, right arm, and unused areas of the left lower leg. These grafts went on to satisfactory take, covering the leg except for exposed bone (Figs 7 and 8).

Twenty-two days following injury, drill holes were placed in the exposed tibia. The leg was taken out of skeletal traction two days later and placed in a bivalved long-leg cast. This was removed four times daily for application of topical antibiotic solution in a wet compress for one-half hour. With this skin grafts matured well and small areas of granulation filled in rapidly.

The boy was discharged 37 days following injury and 29 days following initial skin grafting. At that time he was non-ambulatory, resting in the posterior half of the bivalved

Fig. 11—Case 2. Final result, one year following injury.

long-leg cast, receiving saline and peroxide cleansing to the exposed bone and surrounding granulation tissue four times daily. Ankle physiotherapy had been started before discharge.

Knee motion, active and passive, was begun one week following discharge.

Two months following injury ankle and knee motion were progressing steadily. Granulations were growing slowly over the exposed bone but several screws were still visible. A piece of sequestrated bone was beginning to separate from the patella (Fig 9).

In mid-December 1968, four months following injury, the fracture site was stable by testing, and bone healing posterior to the sequestrum was visible on x-ray films. The screws were removed and the sequestrum fell off easily leaving a granulating surface beneath (Fig 10).

In February 1969, a short-leg cast was applied with a window over the granulating tibial surface. Partial weight bearing was begun.

In April 1969, a long-leg double-upright brace was fitted. He began full-time brace wearing with crutches. The tibial surface was completely healed.

In August 1969, at the time of this report, one year following injury, the boy is in general doing exceedingly well.

Fig. 12—Case 2: Final result, one year following injury.

Fig. 13—Case 2: Final result, one year following injury.

He is up and around full-time in his long-leg brace. The leg is completely covered and there has been no further drainage. The leg has increased in length ⅞ of an inch compared to the opposite leg. An epiphysiodesis is being considered at a later date. With regard to the knee itself, he has essentially a full range of motion with amazingly good quadriceps control. The knee otherwise is stable. The ankle also moves quite freely. In the right foot itself, all tendons are intact with the exception of the posterior tibial which is absent. Since he is in a long-leg brace at the present time, this is not a problem for him.

X-ray films reveal progressive evidence of remodeling of the bone. Within the next year we plan to discontinue the brace.

Discussion

The success of rehabilitation in these two boys seems to be due to these several factors:

1. The early debridement of obviously devitalized skin and soft tissue.

In retrospect it would have been better treatment to remove the denuded skin and subcutaneous tissue at the first operative procedure, on the day of injury. However, one will always feel the obligation to put back skin which has even the slightest chance of survival, as was done here. With wounds left open for inspection, determination of necrosis will be at the earliest possible time.

2. The open treatment of the denuded area prior to skin grafting.

Whether the limb is suspended in skeletal traction or lying on Telfa plastic sheeting, it seems a definite advantage to leave the surfaces exposed to the air. This makes nursing care easier and therefore more frequent and probably retards the growth of surface bacteria.

3. Frequent irrigation and gentle debridement of surface transudates and exudates.

In these cases this was accomplished with the aid of topical antibiotic solution. Whether this is an advantage over a non-antibiotic solution remains to be proven.

4. Early split-thickness skin grafting of all denuded surfaces.

In these cases major graftings were accomplished at five days and three days following the completion of removal of dead skin and subcutaneous tissue. In a case where skin is obviously lost from the outset, grafting should be done immediately at the initial operative procedure.

5. Multiple drill-hole treatment of periosteally denuded sequestrating bone.

This seems to encourage the process of elimination of bone and granulation tissue ingrowth.

Summary

Two cases of massive skin and subcutaneous tissue loss from a lower extremity have been reviewed in detail. Factors which in our opinion are important in the early rehabilitation of such injuries are:

(1) Early debridement of obviously devitalized tissue.

(2) Open treatment of the denuded area prior to skin grafting.

(3) Frequent irrigation and gentle debridement of surface transudates and exudates prior to skin grafting.

(4) Early split-thickness skin grafting of all open surfaces.

(5) Multiple drill-hole treatment of periosteally denuded bone.

ACKNOWLEDGMENTS: Valuable assistance in the management of these cases and in preparation of this paper has been obtained from Dr. S. L. Haug and Dr. D. G. Tompkins, both of the Orthopedic Department, Gundersen Clinic, and from Mr. Joseph Tiedt, Department of Photography, La Crosse Lutheran Hospital.

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22 DIABETES SUSPECTS DISCOVERED IN MASSACHUSETTS DRIVE

Intensive training of volunteer technicians paid off in the discovery of 22 diabetes "suspects" during a Health Fair March 27–30, in Springfield, Massachusetts, according to the August issue of the Disease Detection *Newsletter*.

More than 135 volunteers received comprehensive training in proper blood sugar testing techniques, then applied their training to screen 2,100 persons for diabetes during the four-day Fair. Technicians included medical technologists and registered nurses and students from nursing and technology schools.

Of the 2,100 persons screened 109 had positive primary readings and 22 had positive secondary readings. These 22 diabetes "suspects" were referred to their private physicians for further testing.

Primary screening technique utilized a finger-tip capillary blood test which was read on the spot in one minute. Secondary blood samples were sent to the state laboratories for analysis.

Screening was limited to adults, primarily in the high risk groups, and testing hours were established in midafternoon and early evening to permit two-hour postprandial readings.

The Health Fair diabetes detection program was part of the statewide Massachusetts diabetes screening activity conducted by the state department of health.

The *Newsletter*, a publication devoted to activities in the detection of disease, is issued monthly by the Disease Detection Information Bureau, Chicago. □

THERAPEUTIC DILEMMAS

COLUMBIA HOSPITAL, MILWAUKEE

These ore recorded reporls, which hove been edited, of conferences held on Tuesdoy mornings, 8–9, involving porlicipolion by members of lhe sloff of the hospitol, inlerns, residenls, and guests. They ore published in o selective monner monlhly, excepl Jonuory.

Editor: HARRY BECKMAN, MD, Houghlon Fellow in Clinical Reseorch ond Consulting Physician, Columbia Hospitol

No. 24 of a Series

Sarcoidosis

Moderotor: GHOLI G. DARIEN, MD

Participants: JAMES J. BRILL, MD
DOUGLAS D. KLINK, MD
EDWARD BURG, MD
DONALD SHAW, MD
GUENTHER POHLMANN, MD
GEORGE C. OWEN, MD

Dr. Gholi G. Darien: This morning we are presenting two cases of this very baffling malady, one of them of a distinctly chronic type, the other a recently discovered case. Doctor Brill has the protocols.

Dr. James J. Brill (Intern): The chronic case is that of a 45-year-old white woman, mother of three children, who was hospitalized at a sanatarium for about six months 16 years ago under suspicion of pulmonary tuberculosis. All smears and cultures for tuberculosis, histoplasmosis, and coccidioidomycosis proved to be negative. However, she was treated with isoniazid for two years. At this time a scalene node biopsy was read as compatible with sarcoidosis. At present the patient is in the hospital complaining of low anterolateral chest pain on the left side, intensified by deep breathing and coughing. On admission examination a pleural friction rub was found in the left side of the chest, both anteriorly and laterally. Pulmonary function tests showed a moderate degree of ventilatory restriction with a diffusion defect; a diffuse fibronodular disease was present throughout both lung fields by x-ray examination.

Admission laboratory data: hemoglobin, 12.4 gm; hematocrit reading, 39%; white blood cell count, 10,200 (2 bands, 72 segmenters, 17 lymphocytes, 3 monocytes, 4 eosinophils, 2 basophils); sedimentation rate, 55; BUN, 11 mg/100 ml; uric acid, 4; cholesterol, 254; two-hour postprandial blood sugar, 92; calcium, 9.8; phosphorus, 3.3; protein 7.6 with A/G ratio of 1.1/1.0; albumin, 53%; alpha-1 globulin, 3%; alpha-2, 9%; beta, 14%; gamma, 21%; latex and VDRL tests, negative. An electrocardiogram was interpreted as normal.

While in the hospital her nonproductive cough subsided but there has been complaint of increasing fatigability. It is of interest that a PPD intermediate showed 30 mm of erythema and 16 mm of induration. The family history is negative for both tuberculosis and sarcoidosis.

The recently diagnosed case is that of a 25-year-old white man whose original complaint was chest discomfort following an upper respiratory infection in December 1967, at which time there was shortness of breath, chest pain, and increase in fatigue. Since that time there have been occasional "catches" in the right or left side of the chest and occasional soaking night sweats sometimes with accompanying chills; temperature taken by himself during some of the latter episodes has reached 101 F. There has been a 20-pound weight loss; increased nervousness and decreased appetite have been attributed to the strain of a new job.

Findings on physical examination were within normal limits. Admission laboratory findings: hemoglobin, 17.1 gm; hematocrit reading, 50%; white blood cell count, 8,000 (6 bands, 65 segmenters, 19 lymphocytes, 5 monocytes, 2 eosinophils); sedimentation rate, 2; calcium, 10.2 mg/100 ml; phosphorus, 4. Urinalysis and latex fixation, negative. Protein, 6.6 gm; albumin, 53%; alpha-1 globulin, 3%; alpha-2, 9%; beta, 10%; gamma, 17%. Report on the scalene node biopsy on August 8 was nonspecific hyperplasia. The pulmonary function studies will be reported separately.

A Physician: Was there dyspnea in either patient?

Dr. Brill: There was slight dyspnea in the first patient, none in the second.

Dr. Darien: Thank you, Doctor Brill. Doctor Klink, have you anything to add regarding this second case?

Dr. Douglas D. Klink: This young man was referred to me by an ophthalmologist who had been unable at that time to detect any visual abnormalities, although the complaint had been of blurring of vision. It was a chest x-ray film that actually led to the diagnosis, but subsequent examinations did reveal a few cells in the vitreous. However, the visual symptoms have now completely disappeared, he is feeling fine and has had no corticosteroid therapy.

Dr. Darien: Doctor Burg will now discuss the pathology of the disease.

Dr. Edward Burg (Department of Laboratory Medicine): At the Third International Congress on Sarcoidosis in Stockholm in 1963, the following all-inclusive definition was adopted: a disease of unknown etiology, characterized pathologically by the occurrence in any organ or tissue of epithelioid tubercles with inconspicuous or no necrosis and the frequent presence of refractile or apparently calcified bodies in the giant cells of the tubercles.

The sarcoid tissue reaction is very nonspecific and is actually considered by many observers to be the type of antigen-antibody reaction that can be seen in numerous situations such as tuberculosis, foreign-body invasion, protozoal, viral and bacterial infections. Therefore, when the pathologist sees the so-called sarcoid reaction, or the granulomatous response, he must rule out these other maladies by

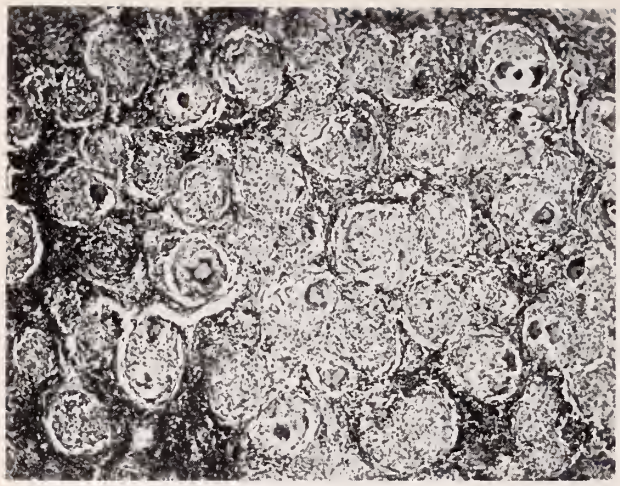

Figure 1

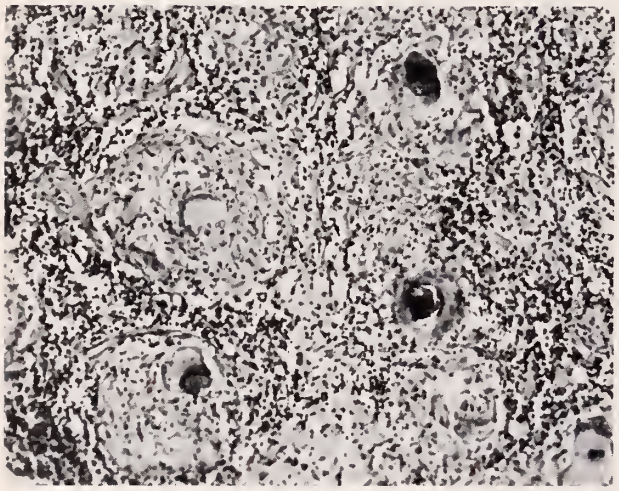

Figure 2

special stains and other studies such as animal inoculations and smears. So the diagnosis is usually one of exclusion. There are certain alerting characteristics of the disease, however. For example, in tuberculosis the granulomata are of variable size and generally one will see caseation necrosis and, if the material is submitted at the right time, fibrosis. The tuberculosis granulomas also tend toward confluence. This provides a polymorphic type of picture, whereas in sarcoid one gets the impression of an iso- or monoamorphous picture in that the granulomas are usually relatively uniform in size, well spaced, and do not show confluence or fibrosis. Furthermore, in sarcoid there are the refractile or inclusion bodies—the Schaumann or conchoid body, which is nothing more than calcification which has become laminated. And there are also asteroid bodies and the microcentrosomes; the former are inclusions in vacuolated areas of the cytoplasm of the giant cells, and the latter very tiny inclusions at the same sites. These findings are *not* specific for sarcoid; asteroid bodies are found in giant-cell myocarditis, and Schaumann and conchoid as well as asteroid bodies are seen in berylliosis.

Figure 3

In short, in sarcoid we have a rather nonspecific granulomatous picture which possesses some characteristics that serve to raise the index of suspicion for the disease—*if* the other diseases have been eliminated.

I show you first (Fig 1) a scalene lymph node section to point out the complete effacement of the architecture; one's first impression is tuberculosis: there are the giant cells of the Langhans as well as the foreign-body type, and there is some fibrinoid or hyaline change. But you will notice that there is no caseation necrosis—which is not a definite differential point because it can be absent in tuberculous lymph nodes and present to a very slight extent in sarcoidosis.

Now here (Fig 2) we have the picture from our first case, the chronic one. This is a cervical lymph node, and you see the rather closely packed granulomas, the absence of caseation necrosis and the classical Schaumann bodies with their laminated appearance that stain as though they were calcium, which indeed they are—they are in the cytoplasm of the giant cell.

In the second case, the young man, there was no suggestion in the lymph node of a granulomatous process; this was simply a nonspecific hyperplastic tissue response.

Dr. Darien: Thank you, Doctor Burg. Doctor Shaw will show the x-ray films.

Dr. Donald Shaw (Resident in Radiology): Sarcoidosis presents radiologically in three forms, with gradations within each, of course. First, there are the large hilar and tracheal nodes; second, a combination of coarse to fine parenchymal nodules with a reticular pattern that may go on to fibrosis and emphysema; and third, a parenchymal pattern only.

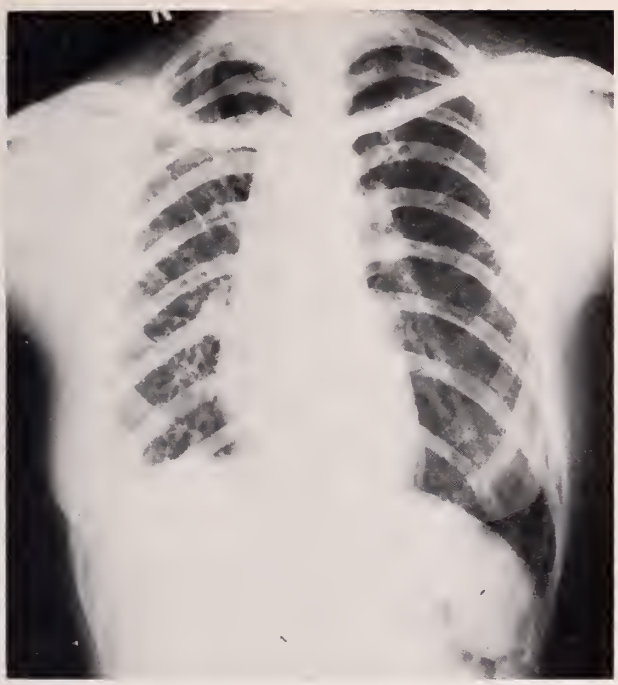

Figure 4

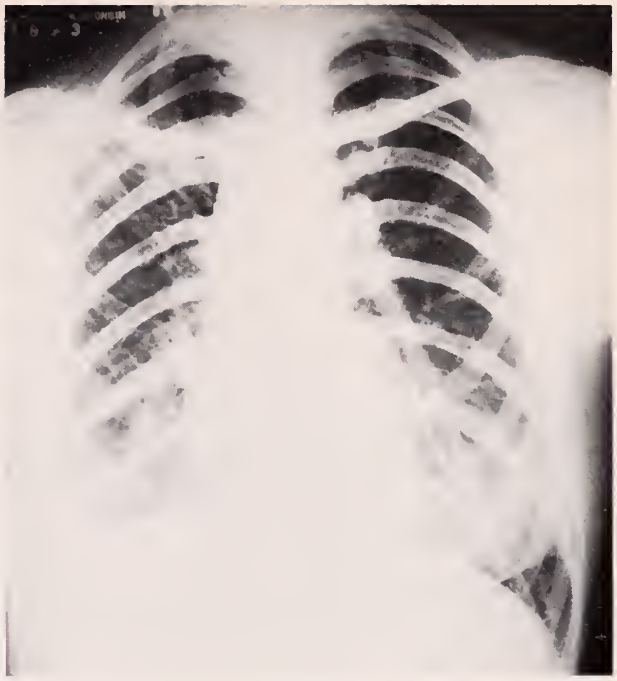

Figure 5

In this film (Fig 3) on the second case, the young man, you can see the bilateral, so-called potato nodes. There is some increase in markings in both upper lobes—I think you can appreciate the right upper lobe infiltrate, the elevation of the minor fissure, and some pleural reaction along the fissure.

In the first case, the chronic one, you can see (Fig 4) the right upper lobe infiltrate. The fullness of the right mediastinum reflects the obliquity and is not lymphadenopathy. In this next film, of 1955 (Fig 5), we are getting a little more of a generalized process, particularly in the right base. This was pretty much the picture through several years, but in 1962 (Fig 6) you see some clearing in the right base, and the right upper lobe component is developing a somewhat fibrotic appearance, with markings in the left upper lobe that are quite coarse. Now in the present [1968] film (Fig 7) there are still the coarse markings in the left upper lobe, and the right upper lobe has a scraggy, fibrotic appearance.

Figure 6

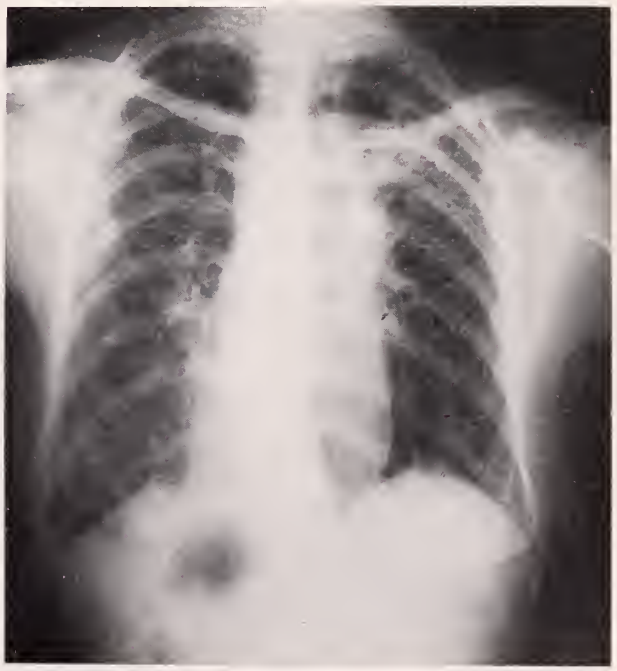

Figure 7

L.S. 5/7/68
LUNG VOLUME

Measurement	Predicted Normal	Observed Value	% of Predicted
VC L.	3.17	1.95	62
FRC L.	2.82	1.73	61
RV L.	1.77	1.04	59
TLC L.	4.84	2.99	62
RV/TLC %	<41	35	-

Helium Mixing Time: 3.0 min.

J.B. 8/6/68
LUNG VOLUME

Measurement	Predicted Normal	Observed Value	% of Predicted
VC, L.	5.33	6.06	114
FRC L.	2.81	2.82	100
RV, L.	1.55	1.24	80
TLC, L.	6.75	7.30	108
RV/TLC %	<35	17	

Helium Mixing Time: 1.0 min.

Figure 8

Dr. Darien: Thank you, Doctor Shaw. Doctor Pohlmann will speak of his pulmonary function findings in our two cases.

Dr. Guenther Pohlmann: I have spirometry, lung volume, and arterial blood gas studies on both patients. In both there are no evidences of obstruction in the spirometry findings, and the oxygen saturations are within normal limits. But in the first case, the chronic patient, there is evidence (Fig 8) of restriction in all compartments: vital capacity, residual volume, and total lung capacity. This is restriction due to the inflammatory fibrotic changes in the lung. In the second case, the recent patient, there is a residual volume of only 80% of predicted while the other compartments run relatively higher, and also the ratio of the residual volume to the total lung capacity is relatively low—which may be the first indication that there is some restrictive disorder going on, because the residual volume is the first compartment in which restriction manifests itself.

In the first patient, but not in the second, we also found a diffusion defect, which appears inconsistent with the finding of normal arterial blood gas tensions. However, this simply indicates that there is a diffusing capacity defect in the area that is restricted; if the alveolar surface is restricted, by definition diffusing capacity is restricted also. In that part of the lung with which the patient is still ventilating, the ratio of ventilated to perfused areas remains normal.

Dr. Darien: Thank you, Doctor Pohlmann. Doctor Owen will now present some of the highlights in the diagnosis, prognosis, and therapy of this disease.

Dr. George C. Owen (Chief, Medical Staff): These two cases presented this morning illustrate many of the problems in the diagnosis and treatment of sarcoidosis.

For example, the young man with subsiding uveitis and large hilar lymph nodes failed to show the nonspecific, noncaseating granuloma in his lymph node biopsy. This does not disturb me because, under the circumstances, sarcoidosis is the only process likely to produce this combination of events. Certainly, if the uveitis were active, I would not delay in treating him with corticosteroids—especially since I have the support in this instance of a most careful student of this disease, Harold Israel (Israel, Harold: *Ann Int Med* 68:1323 [June] 1968). Further, we know that blindness does occur all too frequently as a later complication (Reisner, David: *Am Rev Resp Dis* [Sept] 1967). Because of this, and because later relapse can occur in patients with multiorgan involvement *(Ibid),* I have urged that this young man be followed with great care. Had he had no eye involvement, his prognosis for future trouble with this disease would have been much better. Patients with enlarged hilar nodes alone have the best chance of spontaneous regression. In Reisner's series, over 75% regressed. This is true to a lesser extent of those patients who present with both lymph node and parenchymal involvement, a fact which greatly influences our thinking about the treatment of their cases, and which brings us to our patient with chronic disease.

This lady confronts us with quite different problems than those of our young friend. I first saw her about 20 years ago, because of a routine chest x-ray film taken early in a pregnancy. A soft right infraclavicular infiltrate looked exactly like minimal tuberculosis. Her tuberculin test was positive, and, as you have heard, has remained so. She was treated at a sanatarium where no tubercle bacilli were recovered and no diagnosis was made. Nonetheless, the specter of tuberculosis has hung over her all this while, much as it has over the debates about the etiology of her disease, sarcoidosis. (For those of you who are interested, the history of this debate and current thinking on the matter are brilliantly outlined by Siltzbach in a recent editorial [Siltzbach, Louis E.: *Am Rev Resp Dis,* January 1968].) However, numerous gastric cultures taken at intervals have been negative, and when it became available, isoniazid treatment was carried out with no effect, as you have heard. Over the years, there has been very insidious increase in fibrosis in both lungs without any period of exacerbation, and without any symptoms. In recent years both roentgenologic pattern and physiologic defect have shown no progression. Her present illness is almost certainly an intercurrent viral infection now prevalent in the community.

With this kind of course, I was, in contrast with our other patient, most happy to have histopathologic confirmation of the clinical diagnosis. In fact, under these circumstances it is essential not only to have tissue showing a noncaseating granuloma, but to have special stains and cultures to eliminate as far as possible the many agents, mentioned by Doctor Burg, which can produce this kind of lesion.

Having this kind of information brought me great comfort and, I hope, helped me to give my patient

proper reassurance. Could I have done more? This is the very real therapeutic dilemma presented by this type of sarcoidosis: to treat or not to treat and, if so, when.

There is no question that steroid therapy is the treatment of choice. The indications have been clearly stated in International Conferences on Sarcoidosis (Israel, Harold: Steroid Therapy in Sarcoidosis, *Acta Med Scand,* suppl, 425, p 297 [1964]):

(1) active ocular disease,
(2) progressive pulmonary impairment,
(3) persistent hypercalcemia,
(4) CNS involvement with significant impairment,
(5) disfiguring skin lesions, and
(6) myocardial sarcoidosis.

That's all very well, but in our patient the "progressive pulmonary impairment" was the result, not of active disease, but of irreversible fibrosis, at least by the time it could be detected by careful scrutiny of serial x-ray studies. Treatment here is always useless and sometimes hazardous.

The answer to our question may be forthcoming from two sources: lung biopsies and function studies in early disease which show widespread changes not always seen on x-ray films (Young et al: *Am Rev Resp Dis,* June, 1968) and follow-up studies which suggest that the gross patchy parenchymal lesion has the least chance of spontaneous regression (Riesner, David: *Am Rev Resp Dis,* Sept, 1967). This fits our patient as she presented originally, and I think now I would treat such a patient after observation for some weeks had suggested that spontaneous regression would be unlikely.

What would we have accomplished with steroid therapy? There is no doubt that corticosteroids suppress active sarcoidosis. However, Israel stated a few years ago that it was still unsettled whether this treatment influences the outcome of the disease. He pointed out (Israel, Harold: Steroid Therapy in Sarcoidosis, *Acta Med Scand,* suppl 425, p 297 [1964]) that there had been no controlled studies reported up to that time.

A Physician: What about the use of chloroquine, especially in the skin lesions of sarcoid?

Dr. Owen: Chloroquine is effective in suppressing skin lesions. Because of eye toxicity it should never be used longer than six months and careful slit-lamp observations by a knowledgeable ophthalmologist should be carried out before, during, and after such treatment. Geraint James (*Acta Med Scand,* suppl 425, p 203, [1964]) points out that 50% of patients with eye lesions have skin lesions. This and other systemic manifestations must always be carefully sought for *before* chloroquine is administered. Here *steroids* are mandatory and chloroquine contraindicated.

Dr. Darien: Thank you, Doctor Owen. (Summarizing): This morning we have considered the main features of sarcoidosis as exemplified by two cases, one recently diagnosed and the other of long-standing. Diagnosis, differentiation, and prognosis have been discussed and acceptable guidance for the use of corticosteroid therapy has been offered. □

NEW SCIENTIFIC JOURNAL ON STROKE TO BE ISSUED BY HEART ASSOCIATION

The American Heart Association has announced that it will publish a new scientific periodical entitled "Stroke—A Journal of the Cerebral Circulation."

January 1970 has been scheduled as date of the first issue. The journal will appear bi-monthly thereafter.

The first scientific journal concerned with stroke, it will be of interest to practicing physicians—especially internists, cardiologists, and neurologists—as well as teachers, clinical investigators and laboratory scientists. Articles will include clinical conferences and will be concerned with prevention, diagnosis, treatment and rehabilitation. Research will also be reported in the fields of vascular physiology, pathophysiology, epidemiology, neuro-ophthalmology, radiology and surgery.

Clark H. Millikan, MD, is editor of the new journal. Dr. Millikan is Director of the Clinical Research Center at Mayo Foundation, Senior Consultant in Neurology at Mayo Clinic, and Professor of Neurology at Mayo Graduate School of Medicine at the University of Minnesota.

Cooperating with the American Heart Association in publishing the stroke journal are the American Academy of Neurology and the American Neurological Association.

Further information concerning "Stroke—A Journal of the Cerebral Circulation" may be obtained from the Publishing Department, American Heart Association, 44 East 23rd Street, New York, N. Y. 10010. □

FROM THE LITERATURE

Adipose tissue may fail to metabolize glucose in maturity-onset diabetes, thus causing delay in clearance of glucose from the blood stream and stimulating excessive secretion of insulin. Perhaps more likely, tissue changes—such as raised levels of intracellular fatty acids or citrate—produce alterations in glucose utilization by maturity-onset diabetes—D. J. Galton, et al., *Brit. Med. J.,* March 8, 1969. □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Associate Professor of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

Management of Hepatitis

By J. LE ROY SIMS, M.D., Madison, Wisconsin

THE OBVIOUS SHOULD NOT require emphasis, but repeated experience dictates that in hepatic disease it does—essential to good management is good diagnosis. Passive congestion, a pyogenic abscess, or amebic infestation demand specific therapy. Surgical exploration of a patient with drug-induced cholestasis or with a nonicteric hepatitis which interferes with cholecystography can be disastrous, but biliary cirrhosis from an unrecognized common duct stone is a real tragedy. Until specific positive criteria for its identification are developed, a valid diagnosis of viral hepatitis requires the exclusion of many alternatives, while conversely it must be constantly remembered that hepatitis may be atypical in its presentation and simulate many other diseases.

A great majority of patients with acute hepatitis recover even though not confined to bed, but untoward effects of excessive and fatiguing physical exertion are easily demonstrable; and it is probably wise to restrict most patients with hepatitis to bed or to bed and a chair at the bedside until they are symptom-free, bilirubin has dropped below 2 mg/100 ml, and the transaminases below 100 Karmen units. The psychologic disadvantages of such restriction and those of lack of physical activity should be considered for the individual patient. A discussion with each patient as to the nature and potential courses of his disease offered in a reassuring and encouraging vein is probably desirable early in the course of illness. During convalescence increased activity should be gradual and the patient's response carefully followed. Indications of relapse or an unfavorable course of the original illness should indicate increased restrictions. Rest is also wise in very active phases of chronic disease. In less severe instances the only limitation required may be avoidance of marked stress and fatigue.

Diet should be as appetizing and broadly nutritious as is practical. There is limited evidence that a high protein and caloric intake may speed recovery slightly, but forced feeding is not justifiable and there is no need for drastic limitation of fats. If there is reason to suspect a previously inadequate diet, as in alcoholics, a multivitamin supplement is wise, but in the usual patient has little value. If there is significant fluid retention, salt restriction is in order. In the patient unable to maintain an adequate oral intake, hydration should be maintained and sufficient calories for basal needs supplied by parenteral glucose infusion. Rarely, with prolonged inability to eat, more complete alimentation through an indwelling subclavian catheter may be helpful.

Hepatotoxic drugs and those requiring hepatic conjugation or excretion for their elimination should be avoided. Particularly undesirable are morphine, paraldehyde, chloral hydrate, and short-acting barbiturates. An occasional epileptic becomes comatose because of diphenylhyantoin (Dilantin) retention if full doses of this drug are continued during periods of serious hepatic impairment. If renal function is good, phenobarbital may be used for sedation. For severe agitation accompanying alcohol withdrawal or impending coma, diphenhydramine hydrochloride (Benadryl) or chlorpromazine (Thorazine) may be useful and are commonly well tolerated; they also may be of assistance in control of nausea or itching. If pruritis is a serious problem, cholestyramine may be quite helpful. Alcohol is to be completely avoided and should probably be forbidden for a number of weeks during convalescence, as well as throughout the course of a prolonged or chronic hepatitis.

While adrenal steroids and ACTH may produce amelioration of symptoms and reversion of some indices of hepatic dysfunction, including bilirubin levels, toward normal, they do not seemingly shorten the real course of acute hepatitis, and their premature withdrawal is often followed by relapse. They have no place in the treatment of the usual case. In chronic progressive disease they may render life more comfortable for the patient, and while, in controlled statistical studies, they have not prolonged life, many physicians have the impression that in individual cases with careful adjustment of dosage, that they are of real value. If initiated, they should be continued for several weeks and then reduced gradually and cautiously with careful laboratory control to the minimum dosage which does not permit exacerbation.

At times it is extremely difficult to differentiate

Doctor Sims is Professor of Medicine, University of Wisconsin Medical School.

between intrahepatic cholestasis and extrahepatic jaundice. If careful study does not provide reliable direction, it is best to delay a decision for four to six weeks or slightly longer after the onset of the jaundice and if facilities are available perhaps to perform a percutaneous transhepatic cholangiogram prior to surgical exploration.

Follow-up observations during convalescence from acute hepatitis and some months thereafter are desirable, and where it appears that the disease is not resolving reevaluation as to its etiology is mandatory. In such a situation, needle biopsy may be very helpful.

Bleeding during the course of an acute infectious hepatitis is most commonly the result of some complicating process such as peptic ulcer or esophagitis, and careful search for such a source is necessary. If it appears that prothrombin deficiency is at fault, parenteral vitamin K may be administered, but unless there is a prompt and adequate response within 96 hours, continuation of this agency is apt to be ineffective. If the bleeding site is within the stomach, gastric cooling is advocated by some physicians and ice water gavage may be employed for this purpose. Intravenous vasopressin (Pitressin) [surgical pituitrin], in a dose of 20 units in 100 to 200 ml of saline or glucose administered over a 10- to 20-minute period will lower portal pressure and in many instances result in cessation of active bleeding. It may be repeated every few hours if necessary. Its effect upon systemic blood pressure should be watched carefully because of the possible hypertensive response. Administration of bank blood serves to restore blood volume but will not improve the prothrombin level. Bank blood may have an adverse effect because of its high ammonia or potassium content. Several units of fresh blood or plasma may elevate the prothrombin level and control bleeding, but the effect is quite transient. Where there is a possibility that the hepatic disease is of more chronic nature and gastroesophageal varices the source of bleeding, intravenous Pitressin may still be quite helpful, or the use of Sengstaken tube tamponade life-saving while a definitive diagnosis is being established and therapy planned. Occasionally an emergency portacaval shunt or ligation of actively bleeding varices may be required.

Once the pattern of infectious hepatitis is well established, significant fever is unusual, and any major elevation of temperature should occasion a prompt and extensive search for other causes. Gram-negative bacteremia is not an uncommon occurrence in chronic hepatitis and cirrhosis and should receive particular consideration. Management of coexistent disease should in general be that which would be used in the absence of hepatitis, but with postponement of surgery if at all possible until convalescence, or, in chronic disease, a stable stage of maximum improvement, is well established, and with due attention to the effect of hepatic functional impairment on the handling of any drugs employed. Intercurrent pregnancy presents a difficult problem. Those primary causes of jaundice associated with pregnancy must be differentiated. The hepatitis itself often runs a benign course and the infant is usually normal, but severe or fulminant hepatitis may lead to still births, and morbidity and mortality in the pregnant woman who develops hepatitis is significantly higher than in the absence of the pregnancy. Each case must be judged on its individual merits and carefully followed.

Fluid retention in acute hepatitis is usually mild and requires little attention other than some sodium restriction. In chronic hepatitis ascites may be quite troublesome, although rarely dangerous. Paracentesis should be avoided if possible and in general employed only to relieve pain or respiratory distress, or to prevent impending umbilical rupture. Sodium restriction is almost always in order and should be to a level of 2 gm of sodium chloride per day or less. Serum sodium is often low but unless there is reason to believe that there has been marked sodium depletion because of prior therapy, this usually reflects dilution and internal shifts rather than a deficit of total body sodium and does not contraindicate reduction of sodium intake. Diuretic agents are usually employed. Mercurials may be useful, but are often less effective than in other forms of fluid retention. Hydrochlorothiazide or furosemide (Lasix) are usually the agents of choice. It must be remembered that their use can be associated with elevations of blood ammonia and depression of serum potassium, as may that of ethacrynic acid (Edecrin), and they may precipitate hepatic coma. Simultaneous use of triamterene (Dyrenium) may lessen this tendency somewhat. Spironolactone (Aldactone), while rarely effective alone, facilitates the action of other diuretics. Occasionally when there is difficulty initiating diuresis, water restriction may be helpful until there is some increase in sodium concentration, or prednisone may stimulate a slight pure-water diuresis and produce enough increase in sodium concentration to be helpful. Serum albumin is usually of little value even with severe hypoproteinemia and promptly becomes equilibrated with extravascular fluid compartments, but it may be tried and is occasionally helpful, particularly if renal perfusion is impaired because of low plasma volume. It is possible in spite of massive ascites to have a low intravascular fluid volume and poor renal perfusion which contributes to the development of renal failure. Under such circumstances serum albumin and a high fluid intake may be urgent.

Progressive confusion or lethargy may reflect impairment of hepatic function and be the precursors of frank coma. Possible precipitating factors or alternative diagnoses should be carefully sought and where possible eliminated. Barbiturates, diphenylhydantoin (Dilantin) and morphine are common pre-

cipitating factors in true hepatic coma or may simulate it by greatly prolonged and intensified action due to failure of hepatic detoxification. Azotemia or serious electrolyte disturbances, hypoglycemia, acute infections, massive internal bleeding, and the use of diuretic agents or ammonium salts are other possible contributing factors. If the diagnosis of hepatic coma is accepted, most therapeutic efforts are directed toward eliminating sources of blood ammonia and lowering plasma levels of this or some possibly related toxic agent despite controversy as to their importance in hepatic encephalopathy. Protein should be eliminated from the diet and enough carbohydrate supplied by whatever means is possible to cover caloric needs and eliminate use of body tissue as a source of energy. Physical rest should be enforced if the patient is not comatose. Careful nursing care, with particular effort to prevent aspiration and hypostatic pneumonia, is of primary importance. Thiazides, furosemide (Lasix) and ethacrynic acid (Edecrin), if in use, should be discontinued. The bowel should be emptied by laxatives and enemata and any gastrointestinal bleeding controlled if possible. Hypokalemia or other electrolyte disturbances should be corrected, but treatment of ascites should generally be deferred. An antibiotic effective against ammonia producing bacteria in the intestinal tract should be administered with neomycin or kanamycin (Kantrex) in doses of 1.0 to 2.0 gm every four to six hours being the preferred agents. Paraldehyde, barbiturates, and narcotics should not be used. If agitation requires some type of sedative agent, Thorazine or Benadryl may be effective and reasonably safe. The person with hepatitis is probably no more likely to develop chlorpromazine jaundice than is the person whose liver is seemingly normal. The efficacy of massive doses of corticoids has never been objectively proven, but many physicians who have employed them believe that they are of distinct value. Two hundred to 300 mg of prednisone or equivalent amounts of another corticoid as a single initial dose, with repetition after six hours and gradually decreasing doses thereafter, is a schedule commonly used. Seemingly hemodialysis or peritoneal dialysis should be helpful, but results to date have been disappointing and further evaluation of this technique is needed. Exchange transfusion, which requires the use of large quantities of fresh blood, is a formidable logistic undertaking, but in many instances at least it temporarily improves the level of central nervous system function and in some cases is life-saving, although there are many disappointments. It may be repeated several times if necessary. Such techniques as human and animal cross-circulation, hepatic transplant or extracorporeal perfusion of animal or cadaver livers are still strictly experimental and should be reserved for centers studying these problems.

Transmission of infectious hepatitis is primarily by the fecal oral route, while both this disease and serum hepatitis are transmissible by blood and many blood products. The patient and those in contact with him should be educated as to the infectious nature of the process and the patterns of dissemination. Masks are not necessary since respiratory transmission is exceedingly unusual if it ever occurs. Gowns and gloves should usually be worn by those in actual physical contact with the patient or his bed and the hands carefully washed after any such contact. Linens should be collected and kept in a protective bag until they can be sterilized by appropriate laundering procedures. Dishes and thermometers should be reserved for the patient's sole use or disposable items employed. It is highly desirable that the patient have a private toilet and that maximum cleanliness be maintained in this area, but excreta can be satisfactorily disposed of through the usual urban sewage systems. Such precautions should be continued until the patient is clearly on the road to convalescence and liver function tests reverting toward normal in the case of acute disease. Well established chronic hepatitis need not be considered infectious except as blood or serum exposure may be involved. Patients who have had clinically recognizable hepatitis of either infectious or serum origin should probably not be employed as blood donors at any time in the future, nor should those with chronic disease of unknown origin.

As general prophylactic policies, all needles, syringes, and other instruments which may be contaminated by any patient's blood or excreta should either be of disposable type or should be heat-sterilized after use. In the case of delicate and expensive instruments which would be damaged by heat thorough cleansing is essential. Blood transfusion should be employed only where really necessary, and pooled plasma should not be used. Major effort should be made to maintain good sanitation in camps, custodial institutions, nurseries, and the like.

Pooled human gammaglobulin offers a considerable degree of prophylactic protection against infectious hepatitis. The usual dose is 0.01 ml of the commercial preparation per pound of body weight, or, for an adult, conveniently, the content of a 2.0 ml commercial ampule. It should be administered to those persons having close physical contact with patients who have infectious hepatitis, particularly if they are in high-risk groups such as the very young or very old, pregnant women, and those suffering from other serious diseases. It is also useful when administered to travelers going briefly to areas where there is a high endemic incidence of the disease. For longer residence in such areas 0.05 ml per pound of body weight every three to four months may be desirable. The value of gammaglobulin in prevention of serum hepatitis is less clear and certainly its use is not justifiable after all transfusions; but if there has been clear exposure to serum hepatitis, it is probably desirable to give it to the exposed individual immediately, with repetition of the dosage after four to six weeks and again in eight to twelve weeks. □

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DERMATOLOGY SYMPOSIUM

From papers presented at the 128th Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 14, 1969

DRUG-INDUCED PHOTOSENSITIVITY

By JOHN W. FABER, M.D.
Neenah, Wisconsin

WITH THE INCREASING USE of drugs, both topically and systemically, drug-induced photosensitive dermatitis is becoming an increasing problem for the dermatologist as it is for all physicians. These reactions are unique in that exposure to both light and the drug is required for the adverse reaction to occur. Direct sun light is the usual light source, but diffuse daylight or artificial light may rarely be implicated.

Clinical manifestations vary from mild erythema to severe eczematous eruptions. Characteristically, the eruption is sharply limited to the sun-exposured areas of the body; that is, the face, ears, neck, arms, hands, and back. Typically, the eyelids and the submental areas are spared. This type of dermatitis is to be differentiated from air-borne contact dermatitis which has the same distribution but commonly involves the eyelids and submental angle.

The ingestion of certain drugs may cause a light sensitivity. They include antibiotics (Declomycin, tetracycline or griseofulvin), diuretics (Diuril or HydroDiuril), tranquilizers (Thorazine), antihistamines (Phenergan), and antidiabetic agents (Orinase and Diabinese).

It is of interest that once photosensitization has developed to one of the systemic sulfas, there may be a cross-photosensitization reaction with other sulfa derivatives. For example, a person who has developed a photo-allergic reaction to Diabinese or Orinase may develop a similar reaction to Diuril, Esidrex, or HydroDiuril. Artificial sweeteners, such as Sucaryl and Saccharin contain cyclamates which are derivatives of the same basic sulfonamide molecule which may cause photosensitivity dermatitis. It is well known that hydralazine (Apresoline) and hydantoin medications may produce a collagen-like syndrome associated with photosensitivity that is clinically and pathologically indistinguishable from systemic lupus erythematosus.

Topical contact with a variety of medicaments may also cause a photosensitive dermatitis. Of interest in this group is the rather recent recognition that antibacterial agents used in many common soaps may be photosensitizing. These agents include hexachlorophene, the carbanilides and the halogenated salicyanilides. Soaps which contain these ingredients include Dial, Safeguard, Lifebuoy, Clearasil cleanser, Cuticura, Fostex, Palmolive Gold, Phase III and Zest.

With the avoidance of the offending agent, most patients rapidly improve. However, for some unknown reason a minority of patients retain their sun sensitivity even though there has been no further contact with the photosensitizer. These patients are called "persistent light reactors" and may be so for months or even years.

Other agents which can photosensitize and are used as therapeutic agents topically include psoralens, tar preparations, and sun screening agents (aminobenzoic acid and diagalloyl trioleate). Sulfonamides in topical preparations may cause these problems also. Contact with phenothiazine in commercial insecticides may photosensitize the skin.

The mechanism of photo contact dermatitis is unclear. At present there are two major possibilities:

(1) Ultraviolet radiation cleaves the drug molecule into two free radicals which are then able to combine with protein, probably epidermal in origin, to produce a complete haptenprotein complex capable of sensitization.

OR

(2) This form of contact photo-allergy may really be allergic contact dermatitis due to one of the photodecomposition products.

It is obvious that light is necessary for this reaction to occur, but its precise mechanism is unknown.

As physicians, we must be on the look-out for drug-induced photosensitivity reactions, whether they be from systemic or topically applied medicaments. It is an area which will have interesting importance as we become more knowledgeable about the complexities of adverse drug reactions.

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CONTACT DERMATITIS

By WILLIAM F. SCHORR, M.D.
Marshfield, Wisconsin

CONTACT DERMATITIS, by definition, is a composite of redness, itching, scaling, and at times vesiculation and edema of the skin caused by one or more substances coming in contact with the skin. This is an extremely common disease and the cause of marked and prolonged disability in many areas of our societ. Contact dermatitis represents a heavy financial burden for modern day industry in terms of both time loss and compensation.

This disease can begin as either a primary irritant contact dermatitis or as an allergic contact dermatitis.

The housewife with her daily exposure to soaps, detergents, Handy Andy, Mr. Clean, toilet bowls, ammonia, diaper rinses, sprays, polishes, and the like is a most common prototype for the primary irritant variety. This constant defatting of her hands with physical and chemical irritation can produce hand eczema in any and all housewives after sufficient exposure. The nurse's aide, the bartender, and the auto mechanic all have analogous irritant exposure and may develop a very similar clinical picture. In industry, acids, alkalis, greases, oils, and harsh cleaning agents all take their toll on a primary irritant basis.

I routinely explain to our patients that it is unrealistic to treat these problems unless the patient can temporarily but completely stop all irritant exposure.

Damaged skin or inflamed, eczematous skin, whether caused initially by primary irritant contact dermatitis or by stasis dermatitis, carries with it a higher propensity to become sensitized or to develop a superimposed, true allergic contact dermatitis. It is for this reason we feel a sense of urgency in healing the inflamed skin as rapidly as possible and obtain the patient's cooperation in complete withdrawal from all irritant exposure for two to three weeks.

It is also for this reason that we use medications which have a low sensitization index or a low percentage chance of inducing allergy. Topical therapy with caine drugs, sulfa type drugs, etc. is, therefore, avoided.

Treatment can be effective and yet simple and safe if this principle is fully understood.

If the dermatitis is acutely inflamed with vesicles, weeping, or crusting, we have the patient compress the affected part with plain water for 45 minutes three times a day. Subsequent to each compress the patient gently wipes away all softened pus, crust, and old medications. Then with a cotton ball the patient paints on the following liquid medication.

Rx.	Zinc Oxide	25.0
	Corn Oil q.s.	60.0

The patient leaves the affected part open and at rest. This liniment will not "cake" or pile up on the affected skin and yet will allow the areas to dry and become less acute. The ingredients have very little risk of inducing allergic reactions in keeping with our principle of safety.

Within two to six days we expect the skin to be dry and much less acute. At that time we either stop the compresses or reduce them to once daily and also discontinue the liniment. It is at this stage of dry, red or pink skin that we begin topical steroid therapy. Triamcinolone, flurandrenolone, betamethasone, and fluocinolone are all highly effective. Hydrocortisone can also be effectively used. If the dermatitis is still fairly red and inflamed, a vanishing cream base should be selected. If the area has become quite dry, I have found it helpful to mix equal parts of the steroid in a vanishing cream base with equal parts of the same medication in an ointment base. For optimum efficacy the patient is instructed to rub the medication in gently but well four to five times a day. Intertriginous areas such as the axilla and groin are always treated with a vanishing cream base.

In the very acute or extensive contact dermatitis, a ten-day decreasing dose of prednisone starting with 40 mg daily for the first two days may greatly reduce disability without significant risk to the patient. We do not ordinarily use oral steroid therapy for chronic, long-term dermatologic problems.

This abstract will be published in *Conn's Current Therapy*, 1970 edition, W. B. Saunders Co.

Within two or three weeks the majority of patients with primary irritant contact dermatitis will be healed on the above program and then investigation as to etiologic or provocative factors can be made.

If the problem is obvious, such as housewives' eczema or its counterpart in bartenders and nurse's aides, the patients shoud be instructed to gradually go back to their workload. Dishes can be done once a day instead of three times a day, and strong irritants can be avoided. Unlined rubber gloves cause maceration and irritation and should be avoided. If they are worn during the period of dermatitis, this dermatitic skin may develop allergy to the rubber antioxidants and rubber accelerators and cause greater disability.

If irritant exposure is chiefly moisture, then the Dow Corning New Formula Hand Protector can be applied prior to wet exposure and has been of help in our hands.

The treatment described above can be used just as effectively with the allergic form of contact dermatitis. Allergic contact dermatitis involves detective work and its investigation can be enjoyable and rewarding. The obvious clues of nickel dermatitis from earrings, especially if the patient has recently had her ears pierced, or the metallic exposure to bra clips, garter clips, or watch bands should not go unnoticed. The glove-like pattern of contact dermatitis due to rubber gloves, the dermatitis on the dorsa of the great toe and adjacent foot caused by thermoplastic box toes of shoes or other sandal-like patterns of contact dermatitis with shoe chemicals are meaningful. The allergic pattern of rubber antioxidants or rubber accelerators in the elastic portion of bras, girdles, or the waistband of undershorts; the streaks of vesicles from poison ivy; the patches or streaks of dermatitis on the eyelids, sides of the neck and cheeks from scratching these sites with polished nails; and the dermatitic patterns coinciding with the application of perfume are all important. If the problem is not simple and needs a detailed examination with appropriate patch testing, dermatologic help may be called for. Patch tests are reliable and effective procedures only when used in trained hands. Patch tests applied during acute dermatitic flares result in false positive tests and at times an exacerbation of the disease. There is a correct, safe testing concentration or dilution documented in dermatologic literature for most chemicals. The concentration must be high enough to elicit a true allergic patch test reaction in our standard 48-hour closed patch test and yet not be so high as to cause a nonspecific primary irritant response when applied to normal control volunteers.

When dealing with a generalized dermatitic problem which has been of long standing, hospitalization for contact isolation is of great importance. We allow nothing to come in contact with the patient's skin except his eating utensils, well rinsed hospital bedclothes, and the TV set. If we then treat this patient with medications which he is not allergic to, he has to recover if the diagnosis is correct. The allergen can be an ingredient common to any or all creams or lotions prescribed by the doctor such as paraben preservatives or lanolin. To avoid this hazard, treatment can begin with 1% hydrocortisone in Crisco. The allergic potential here is close to zero.

It is not possible to even begin to cover the full spectrum of allergic contact dermatitis in a brief chapter of this type. However, I feel an additional word should be said about photocontact dermatitis. With increasing frequency we see patients in our office who have redness, scaling, and edema of the sun-exposed areas of the face, back of the hands, and the arms. The patient can develop a photoallergy or a true photocontact dermatitis to chemicals applied to the skin such as the halogenated salicylanilides which are used in most of our germidical soaps. Recognition of this pattern is extremely important so that such exposure can be quickly terminated. If the skin is not too acute and if the patient can be treated on an outpatient basis, we have found it effective to use the following.

Rx.	Triamcinolone 0.5% Cream	15.0
	RVP Sunscreen q.s.	60.0
Sig.	Rub in well q.i.d.	

Herein we have a relatively high concentration of an effective steroid mixed with a sun protective agent. There are many such combinations which can be made up by the physician. This is merely one example.

TINEA VERSICOLOR

By JOHN R. MARNOCHA, M.D.
Green Bay, Wisconsin

TINEA VERSICOLOR is a frequently seen superficial skin infection. The etiologic organism, Pityrosporum orbiculare, is one of the lipophilic members of the skin's microflora. It primarily involves the 20-to-40-year age groups of both sexes and is worldwide in distribution.

Susceptibility to this disease is seen in concurrence with a diversified number of predisposing factors. The condition presents itself as various shades of yellow-brown colored scaling patches primarily of the anterior upper trunk. Microscopically, the scales show characteristic spore clusters and short hyphal elements. Cultures are usually of no value. Wood's light examination may produce a golden fluorescence.

A multiplicity of therapeutic agents have been recommended with a high recurrence rate following all of them.

PYOGENIC GRANULOMA

By DONALD S. SCHUSTER, M.D.
Madison, Wisconsin

A PYOGENIC GRANULOMA is a benign tumor common in children, resulting from an injury at an infected site or an injury that abrades the skin and subsequently becomes infected. The lesion is usually red and pedunculated, although it may be papular or nodular and becomes darker in color as it becomes older. It will bleed easily when traumatized. It may be treated by scissors excision and electrodesiccation and curettage of the base, or if deep, by elliptical excision.

The lesion should be studied pathologically because other conditions may resemble it, such as melanoma, hemangioma, keratoacanthoma, nevus, verruca, molluscum contagiosum, glomus tumor, and Kaposi's sarcoma. Occasionally the lesion recurs,[1] and this may occur at or about the original site. Therefore, a baseline pathological study of the primary lesion is quite important, for one would naturally be concerned about the possibility of malignancy. Satellite recurrences often appear over the bony prominence of the scapula and may develop as long as four months after the primary has been surgically removed.

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PITYRIASIS ROSEA

By MARVIN S. KAGEN, M.D.
Appleton, Wisconsin

PITYRIASIS ROSEA was described by C. M. Gibert in 1860.

"Small fufuraceous spots which are very lightly colored, irregular, scarcely exceeding a fingernail in size, numerous and close set, although always separated by some interval of normal skin, pruritic, and which appear on the superior parts of the body, with a predilection for the neck, the upper part of the chest, and the upper part of the arms, but which may spread successively from above downwards as far as the thighs, in such a way that the total duration of the eruption, which disappears little by little from the parts first affected as it moves downward, is protracted quite commonly to six weeks or two months."

One hundred and nine years have passed since the disease was first described, and the disease has not changed.

The cause has not been discovered, but it behaves very much like a virus. Only 3% may have a recurrence. Occasionally, it will occur in families or close contacts.

Pityriasis rosea

Pityriasis rosea occurs in 1% to 3% of all skin patients. It occurs in an equal number of males and females. The ages of patients vary from 3 months to 70 years. However, it is most common from 10 to 40 years.

The disease is a little less common in the summer. The incidence is higher in patients with eczema or seborrheic dermatitis.

The illness may be precipitated by pregnancy or medication such as iron, gold, bismuth, arsenic, tetracyclines, or salicylates.

The primary plaque, which is usually referred to as a "herald patch," occurs in 80% of the patients. It is the largest patch, appearing three hours to three months before the generalized eruption. The interval is usually within three weeks. The primary plaque is on the chest in 50%, arms 20%, and legs 15%.

The generalized eruption is most common on the chest, but may occur on any area. Occasionally, only the neck and face are involved. Women appear to have more lesions on the abdomen.

The eruption lasts six weeks or less in 85%, and three weeks or less in 40%. Itching is severe enough to disturb sleep in 20%, moderate in 40%, slight in 20%, and absent in 20%. One-third of the patients develop an increase or decrease in pigmentation with the clearing of the lesions.

The laboratory findings are not significant.

Early biopsy reveals a mononuclear perivascular infiltrate. This is followed by parakeratosis, acanthosis, spongiosis, vesicle formation, and exocytosis.

Pityriasis circinata et marginata of Vidal is considered a variant of pityriasis rosea with involvement of the axillae and groin.

The differential diagnosis involves: (1) seborrheic dermatitis which has involvement of the scalp,

eyebrows, and central one-third of the body; (2) pityriasis rosea-like drug eruption brought on by medicine like gold which may last longer than eight weeks; (3) secondary syphilis which has oral and genital lesions with a reactive VDRL; (4) guttate psoriasis which has bright red papules with silver scales; (5) acute parapsoriasis which has purpuric papules, vesicles, and ulcerations; (6) pityriasis alba with erythema and scaling patches on the face of an atopic child; and (7) tinea glabrosa with erythematous and vesicular borders that show fungi with a KOH preparation.

I carefully observed 19 patients with pityriasis rosea. Most of the patients had involvement of the body. Their ages were 10 to 40 years. Seven were male and 12 were female.

Therapeutically, I found .0125% triamcinolone acetonide in Cetaphil lotion to be helpful in cutting down the itching and hastening the recovery. Cetaphil lotion was applied on one side of the body and the Cetaphil lotion plus Kenalog on the other side. The lotion with the Kenalog was more effective in 75% of the patients.

One and one-half milliliters of Kenalog-IM was added to a pint of Cetaphil lotion to make a .0125% triamcinolone acetonide lotion. A 4-oz. bottle of this lotion is adequate for a patient if applied twice daily. Soap should be avoided while the eruption is present.

AN UNUSUAL CASE OF DERMATOMYOSITIS

By ROGER LAUBENHEIMER, M.D.
Milwaukee, Wisconsin

THIS 46-YEAR-OLD white woman first noticed the onset of a dermatitis about one year ago. It started as a red rash on her face, which spread to involve her arms, legs, and the trunk of the body. She saw several physicians because of the pruritus, and her problem was diagnosed as that of an allergic dermatitis. She received various treatments to control the itching. She was also studied by an allergist and found to be sensitive to house dust and was given a series of desensitization inoculations.

When I first saw her six months ago, she had large patches of atrophy, telangiectasia, and scaling scattered on the face, neck, buttocks, trunk, and a few lesions on the arms and legs. My first clinical impression was that of poikiloderma, and a biopsy supported that diagnosis with the possibility that she had lupus erythematosus or dermatomyositis.

She was then admitted to a hospital and studied extensively. We were unable to establish a diagnosis of dermatomyositis because the electromyogram studies were normal. Her sedimentation rate was normal. The SGOT and all electrolyte studies were within normal limits. We did an extensive search for carcinoma because 17 years before she had had a carcinoma of the breast and had received radiation therapy, oophorectomy, and hormonal treatment after her radical mastectomy.

Over the next two months after she was discharged, her symptoms became more progressive. She then developed muscle weakness and difficulty in swallowing. She was again admitted to the hospital, and now the sedimentation rate was markedly elevated, the SGOT levels were elevated, but electromyogram studies were reported as normal. A muscle biopsy showed no specific change of the muscles. Again, we were unable to find any evidence of carcinoma until she developed an aspiration pneumonia after the barium swallow which we had employed for the study of her dysphasia. With bronchoscopy, we noticed that there was an obstruction external to the bronchus. A scalene lymph node biopsy then revealed metastatic carcinoma from the breast. The cells looked very similar to the cells which were removed 17 years before.

With the use of high doses of steroids and radiation therapy to the mediastinum, this patient has made good improvement. After six weeks of therapy, she was able to leave the hospital.

The only other information which may be significant is that approximately one year before the onset of her symptoms, she was started on estrogen because of vaginal dryness.

LICHEN PLANUS

By JAMES F. HILDEBRAND, M.D.
Sheboygan, Wisconsin

LICHEN PLANUS was first described by Erasmus Wilson in the *Journal of Cutaneous Medicine* in England in 1869. Today, looking back 100 years, much of the original description could not be improved upon. Here are some quotations out of context:

> "Lichen planus is an eruption of pimples remarkable for their color, their figure, their structure, their habits of isolated and aggregated development, their habitat, their local and chronic character, and for the melasmic stains which they leave behind when they disappear. The color of the pimples is a dull crimson-red, more or less vivid and suffused with a purplish or lilac tinge. In figure, the papulae are flattened, smooth, and depressed on the summit, angular in outline, only slightly elevated, and of a size ranging between one and three lines in diameter, and this peculiarity of figure is so striking, that we have selected it as the pathognomic characteristic of the eruption."

Lichen planus is usually symmetrical, and appears commonly on the volar aspect of the wrists, the legs, the sacral area, and on the mucous membranes of the mouth, vulva, or glans penis.

The wrists usually exhibit typical primary papules.

The lower extremities often exhibit hypertrophic, lichenfied, pruritic lesions.

The sacral area often exhibits a confluence of papules.

The glans penis often exhibits papules in annular arrangement.

Usually chronic, lichen planus may occur in acute form, rarely even vesicular or bullous. Itching is not constant, but may be severe and very difficult to control. However, in the hypertrophic form on the lower extremities significant itching is usually present.

Although in itself a benign disease, two situations involving the mucous membranes must be considered:

First, any white patch of the mucous membrane which exhibits thickening, even when accompanied by other typical lesions of lichen planus, should be biopsied for leukoplakia.

Second, in the rare cases of chronic erosive lichen planus of the mouth, regular observation for possible development of squamous carcinoma is indicated.

The etiology of lichen planus is unknown, and there is no specific therapy. Treatment is symptomatic, the same as for any other benign skin condition.

In closing, may I leave you with this thought . . .

If you have lichen planus . . . You can bet your sweet flat papules that their color will be violaceous. □

PRIMARY DISSEMINATED PULMONARY ASPERGILLOSIS WITH METASTATIC SKIN NODULES; Successful Treatment with Inhalation Nystatin Therapy

JAMES S. VEDDER, MD, and WILLIAM F. SCHORR, MD, Marshfield Clinic, Marshfield, Wis: *JAMA* 209: 1191–1195 (Aug 25) 1969

The diagnosis of extensive pulmonary aspergillosis with multiple metastatic skin lesions was established in a 3½-year-old female child who had had no known prior debilitating disease. The hyphae of *Aspergillus* were identified in both the skin and lung biopsies. In addition, *Aspergillus fumigatus* was cultured from the lung biopsy material. A reversal and clearing of the disease process occurred in both the lungs and the skin after a few weeks of aerosol nystatin therapy. Oral nystatin therapy did not produce a remission and did not control the disease. Inhalation nystatin therapy consisted of 1,500,000 units of nystatin dissolved in 500 cc of a 10% propylene glycol solution. The entire 500 cc was vaporized in a mist tent each night between 8 PM and 6 AM. Serum assays of the patient's blood showed nystatin serum levels of 2.8 to 3.7 units/ml of serum while the child was on inhalation therapy. No nystatin level could be recorded on oral therapy alone.

Finegold and coworkers in the AMERICAN JOURNAL OF MEDICINE in 1959 revised the classification of aspergillosis. They divided it into primary aspergillosis, which arises without the presence of an antecedent disorder, and secondary aspergillosis, which is always associated with underlying debilitating disease, or antibiotic or steroid therapy. Secondary aspergillosis is not an uncommon disease. Primary aspergillosis with specific cutaneous fungal granulomas is an exceedingly rare medical entity. □

Read before the Section on Dermatology at the 118th annual convention of the American Medical Association, New York, July 15, 1969.

NEW RESEARCH . . .

Clomacran: Improved significantly 21 of 25 female schizophrenic patients when given over a 2 month period in dosages of 150 to 600 mg daily. Clomacran is the generic name for Smith Kline & French's test drug, formerly code-named SKF 14336. By William T. Lampe, II, Harrisburg State Hospital, Harrisburg, Penna.—Reprinted from AMERICAN DRUGGIST, July 14, 1969 □

"TYLOSIS PALMARIS ET PLANTARIS"

DIANA D. PARNELL, MD and STURE A. M. JOHNSON, MD, University of Wisconsin, Madison, Wis: *Arch Derm* 100:7–9 (July) 1969

The association of familial tylosis (hyperkeratosis) of the palms and soles and carcinoma of the esophagus is well documented. Since both the esophagus and bronchus are derived from the foregut, one might also expect to see carcinoma of the bronchus associated with keratoderma.

A 49-year-old woman with metastatic bronchogenic carcinoma and concurrent tylosis of the palms and soles is presented along with a 58-year-old man with metastatic esophageal carcinoma and similar skin lesions. A review of the charts of 266 patients with esophageal carcinoma disclosed 3 additional patients with these skin lesions. Acquired tylosis appears to be another cutaneous manifestation of internal malignancy. □

STATEMENT OF COMMITTEE ON IMMUNIZATIONS & INFECTIOUS DISEASE WISCONSIN CHAPTER AMERICAN ACADEMY OF PEDIATRICS

OCTOBER 1969

RECENT ADVANCES have modified long-held concepts of the management of tuberculin reactors and the treatment of active disease. Childhood tuberculosis now may often be handled by physicians caring for children in general hospitals or at home. Up-to-date knowledge thus becomes important.

1. Significance of the Tuberculin Reaction. A positive reaction indicates the presence of allergy to tuberculin and that actual infection of the child has occurred. These tubercle bacilli may remain dormant for decades.

There is much evidence now that adult tuberculosis is due to reactivation of a dormant focus, *not reinfection.*

2. Using Isoniazid for Tuberculin Reactors. It has been shown by U. S. Public Health Service studies that *all* tuberculin positive reactors (regardless of age of duration of conversion) would benefit from a year of Isoniazid medication.

In children, certain priority groups should definitely receive Isoniazid for one year. These include:

a. Any child four years or under who has a positive tuberculin test (treat adequately. Usually active disease present).
b. Recent converters—within 12–18 months.
c. Recent contacts of open tuberculosis cases.
d. Converters of unknown duration who are adolescents or residents of high-risk environments.
e. Children with very large skin reactions.
f. Positive reactors with doubtful lesions on x-ray film.

In addition, positive reactors who have measles or pertussis, are immunized with live measles vaccine, undergo major surgery, receive major trauma, are on steroids, antimetabolite or alkylating agent therapy or have uncontrolled diabetes should be treated for an appropriate time.

3. Isoniazid Dosage. 15–20 mg/kg daily in one dose (up to 300 milligrams per day) usually given before breakfast.

For progressive, chronic or ill children 20 mg/kg of Isoniazid is divided into two doses and given orally, I.M. or I.V. Streptomycin (30–50 mg/kg per day) and PAS (200–300 mg/kg per day) are usually also indicated.

4. Household Contacts. Careful surveillance of family contacts (including baby-sitters) with periodic recheck is advised. Tuberculin positive reactors should be treated for one year. The U. S. Public Health Service has found that treating household contacts, both tuberculin positive and negative, is effective.

5. School Contacts. Classmates should be tested and reactors treated. If an unexpected number of positive tests are found the entire school should be tested. Adults in the school are the usual source of a case and screening should include full and part-time teachers, clerks, janitors, lunch room personnel, etc.

6. Contagion. Children with primary tuberculosis are rarely contagious (even if the gastric washings are positive) and need not be isolated. Children with asymptomatic primary tuberculosis may return to school with the initiation of chemotherapy (I.N.H.).

7. Isoniazid may be obtained for prophlyaxic use at no cost to the patient from the Department of Health & Social Services, Madison, Wisconsin.

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Personal Communications: William W. Stead, MD, J. C. Peterson, MD, E. Richard Stiehm, MD.

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THERAPEUTIC DILEMMAS

COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They are published in a selective manner monthly, except January.

Editor: HARRY BECKMAN, MD, Houghton Fellow in Clinical Research and Consulting Physician, Columbia Hospital

No. 25 of a Series

THE "HOT" THYROID NODULE

Moderator: MAYNARD D. POLAND, MD

Participants: JAMES J. BRILL, MD
GUENTHER POHLMANN, MD
ROBERT R. KOENIG, MD
SANFORD R. MALLIN, MD
DONALD M. WILLSON, MD
GLENN H. FRANKE, MD
PHILIP H. SEEFELD, MD

Dr. Maynard D. Poland: Although the topic this morning will be principally discussed by Dr. Sanford R. Mallin, as endocrinologist, I am sure other viewpoints are likely to be expressed. Doctor Brill will present the case.

Dr. James J. Brill (Intern): A 65-year-old white woman was first admitted to this hospital in the summer of 1968 with chief complaint of diarrhea which had occurred intermittently for the previous two years; nausea and vomiting began the day prior to admission. During this hospitalization the gastrointestinal symptoms responded to irritable bowel therapy; however, a firm, movable, mildly tender nodule measuring 2–3 cm lengthwise and 1–2 cm laterally was palpated in the right lobe of the thyroid, with no satellite nodules apparent. She was emotionally labile, but otherwise there was no stigmata of hyperthyroidism. Scintiscan revealed a "hot" nodule in the right lobe; a repeat scan after T_3 suppression was recommended but not performed. The patient was discharged on 3 grains of desiccated thyroid which she took until mid-January 1969 (6 months later), when she returned for thyroid resection because the nodule had not changed.

The day before thyroid surgery, there were no significant findings on physical examination except for the thyroid nodule. The patient was discharged on the 4th postoperative day after an uneventful recovery except for continued emotional lability.

Dr. Poland: Doctor Pohlmann will present and interpret the I^{131} uptake and scintiscan study.

Dr. Guenther Pohlmann (Department of Laboratory Medicine): The patient's thyroid scan (Fig 1) shows an area of relatively high I^{131} uptake in the right lobe, which is the area of the palpable nodule. As you see, the 24-hour I^{131} uptake and the conversion ratio were compatible with normal thyroid function—but still in agreement with a so-called "hot" or hyperfunctioning nodule. There is, however, some thyroid tissue visible in the left lobe and also some in a remnant of the right lobe. I think that it would have been very helpful to have performed a TSH stimulation test in this case to determine the nature of this tissue; i.e., to determine whether it is fibrotic nonfunctioning tissue as a result of a thyroiditis or fibrosis, or whether it is functioning tissue that is being suppressed by the autonomous nodule. If such a nodule responds, we would then know that it is autonomous and independent of feedback regulation, and the administration of exogenous thyroid would probably be useless.

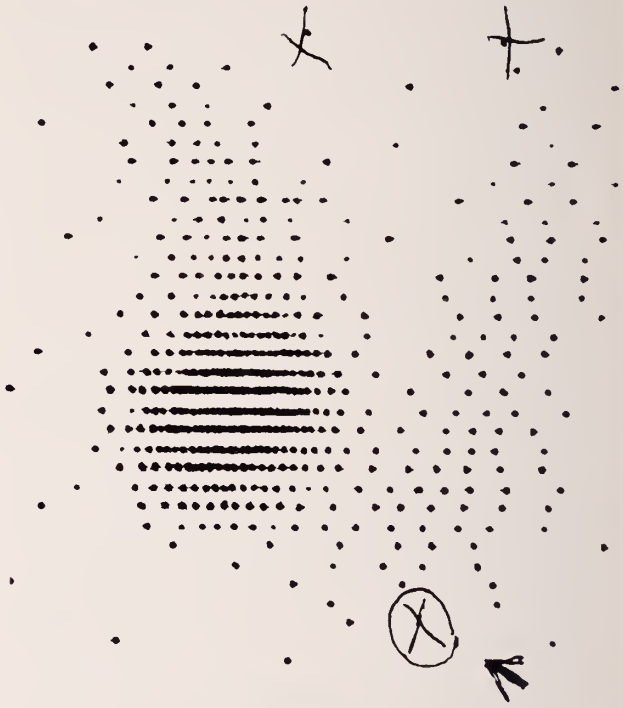

Figure 1

Dr. Poland: Doctor Koenig will show photomicrographs of the nodule removed at surgery.

Dr. Robert R. Koenig (Department of Laboratory Medicine): Of the two pieces of thyroid tissue that were submitted, the larger one, measuring about 2.5 cm in diameter, contained the nodule that you saw on the scan. This was typical follicular adenoma. Here (Fig 2) you see the capsule that surrounded the tumor—normal thyroid tissue above, and below it the nodule composed of follicles of varying size, all very well differentiated. The next picture (Fig 3) presents a high-power view revealing that the follicles are lined by a single layer of cuboidal epithelium with small dark nuclei. The colloid is very

Figure 2

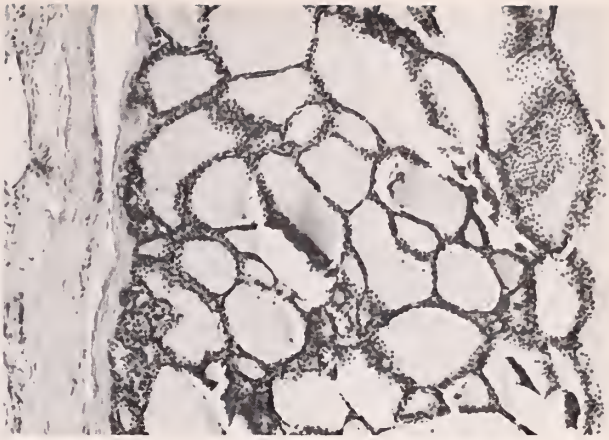

Figure 3

homogeneous and all the follicles are very actively producing it. We therefore considered this a typical "hot" nodule.

Dr. Poland: Doctor Mallin will now discuss the subject of the "hot" thyroid nodule.

Dr. Sanford R. Mallin: To begin my discussion of this topic, I would like to define the "hot" nodule as an area in the thyroid that is simply functioning more than surrounding areas of the gland. The differential diagnosis of such a nodule would include: (a) the autonomous type, which is present in our case this morning; (b) the type which reflects agenesis of the contralateral lobe; (c) the surgical remnant in a patient who has had Graves' disease, a remnant which may be working overtime to provide the body's requirement of thyroxin; and (d) the type alluded to by Doctor Pohlmann in which degeneration, inflammation or previous thyroiditis has left a single area in which there is function on a scan.

The autonomous nodule is defined as one that is functioning independently of thyroid stimulating hormone (TSH). This independence is demonstrated by the fact that administration of thyroxin, or thyroid in any form, does not affect the activity of the localized nodule. The thyroxin would presumably shut off TSH production in a normal gland, but the activity of an autonomous nodule does not change, suggesting that TSH is already suppressed. On the other hand, exogenous TSH administration lights up the remainder of the gland, which confirms the fact that the thyroxin produced by the nodule has been preventing autogenous TSH production. In our present case, the evidence, in Doctor Pohlmann's scan, of small amounts of active tissue in both lobes suggests that the nodule has not completely deprived the gland of TSH influence.

Interest in the relationship of the "hot" nodule to thyrotoxicosis began with Cope's description of 10 cases in 1947 (Cope, O., et al.: *Surg. Gynec. and Obstet.* 84:415, 1947). As a result of his study he concluded that such a nodule would be a relatively uncommon cause of hyperthyroidism, and I think the experience of most of us supports this observation. The origin of this disease appears to be entirely different from that of diffuse goiter of the Graves' type. He also postulated the theoretical efficacy of radioiodine therapy in reducing the activity of this localized area of hyperfunction. In cases coming to surgery it has certainly been found advisable to remove only the hyperfunctioning nodule, leaving the remaining hypofunctioning gland intact since it is hypofunctioning only because of the suppression of TSH formation through the activity of the nodule.

Sheline's article, in 1960 (Sheline, G. E. and McCormack, K. J.: *Clin. Endocrin.* 20:1401, 1960), was the first in which it was intimated that perhaps many of these cases are best handled through mere observation without active therapy since many of the patients are euthyroid. Of his 15 patients, 10 were euthyroid, and no complications developed in the 5 of these who were given no therapy at all. Subsequent studies by other investigators have been contradictory, however. For instance, in a report from the Cleveland Clinic (Skillern, P. G. et al.: *Arch. Int. Med.* 110:124, 1962) all 46 patients in the study were described as being toxic, while another report, that of Silverstein, to be quoted later, described as euthyroid 19 of 22 patients. It is perhaps of some importance to us to note that one-half of the patients in the Cleveland Clinic series had normal 24-hour I^{131} uptakes; these patients did not have eye signs and there was very little hypothyroidism following therapy. The radioiodine given in therapy usually concentrates in the nodule and the remainder of the gland is relatively unaffected by the radiation. This Cleveland observer found, however, that although the nodules generally became smaller under this therapy they did not disappear, and he therefore advocated surgical treatment because he was disturbed by the large amount of irradiation it had been necessary to use to accomplish only partial ablation.

In a large series, recently reported from the Mayo Clinic (Molnar, G. D., et al.: *Mayo Clin. Proc.* 40:665, 1965), 25 of the 34 patients were toxic and 9 euthyroid. Surgery was employed in 20 of the cases, 12 received radioiodine, and 2 had no treat-

Figure 4

Figure 5

Figure 6

ment at all. In 11 of the 12 patients treated with radioiodine, there was shrinkage of the nodule but it did not disappear in any instance. These observers therefore felt that surgery was the therapy to be preferred. They were concerned about the possibility of malignancy in association with a hot nodule, but Miller and Hamburger (Miller, J. M. and Hamburger, J. I.: *Radiology* 84:66, 1965), reviewing the entire literature of this subject, failed to find any substantiated cases in which it had been shown that a benign adenoma had converted into a malignant lesion. In the small number of cases in which carcinoma has been found in hot nodule glands, the malignant lesion has been independent of the adenoma.

A paper which has coincided a little more closely with my personal experience appeared from the Michael Reese Hospital in 1967. Some of the patients included in this study of Silverstein's group (Silverstein, G. E., et al.: *Ann. Int. Med.* 67:539, 1967) I am familiar with myself. The most interesting group are 9 individuals who have been followed for periods ranging from two to seven years, with a mean of four years. These patients have pursued a more variable course than has been described in the earlier literature. Four of them retained the autonomy of their nodule without significant change, all remaining euthyroid. In 1 there seemed to be a diminution in autonomy, since the remainder of the gland began to light up a bit. In 3 of them there was reestablishment of TSH dependence; i.e., whereas at one time their nodules were clearly "hot" with autonomous nonsuppressible function, at a later time triiodothyronine administration lowered the activity of the previously autonomous nodule. One of the nodules degenerated. The size of these nodules varied from 3 to 6 cm in diameter, making it appear that mere size of the nodule is not in itself significantly helpful in evaluating these cases.

From my own present practice I should like to cite just one case that has now been followed for four years with a type of course that has not yet been reported in the literature to my knowledge. The patient, a 42-year-old white man, had been found by the referring physician to have a small left lobe nodule that had not been present one year previously. Scan had revealed (Fig 4) an enlarged left lobe with a very small area of decreased function in the upper pole. The patient was euthyroid at this time and the 24-hour I^{131} uptake was 27%. In a second scan, taken two months later (Fig 5), you will note that the function of the right lobe has been almost completely lost and the area of degeneration in the left lobe is somewhat larger. I interpreted these changes to mean that at the time of the original scan the left lobe was autonomous but that it was only "warm" and not "hot." In the interim it had produced sufficient additional thyroxin to shut off the TSH supply completely, and as a result the right lobe had ceased to function.

The patient remaining euthyroid, I decided several months later to suppress him with thyroid to see what would happen. What did happen was that on 0.2 mg of levothyroxine (Synthroid) he developed tachycardia, palpitations and diarrhea. He did not become intolerant to heat and he wasn't jittery or nervous; in fact he lacked many of the classical signs and symptoms of Graves' disease. But there

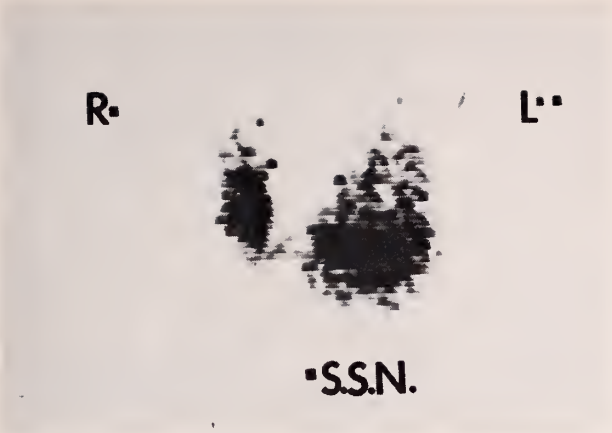

Figure 7

Figure 8

appeared to be no doubt that we were making him hyperthyroid with the medication.

The nodule remains "hot" and continues to suppress the other lobe (Fig 6) and the area of degeneration persists in the upper pole. (Parenthetically I would remark that areas of degeneration of this sort, cystic or hemorrhagic, are frequently described in the literature and are not associated with malignancy). This scan was done in September 1965, and the I^{131} uptake at 24 hours was 29%. Six months later, in March 1966, without any treatment at this time, lo and behold, we have a right lobe back again (Fig 7)! This, it seems to me, can only be interpreted to mean that there has been some decrease again in thyroxin synthesis by the autonomous left lobe with resultant appearance of TSH and recovery of right lobe function. In the last scan, in December 1967 (Fig 8), the right lobe has again been nearly lost. Here then we have a second demonstration in the same patient of a warm nodule becoming a hot nodule.

I do not feel that every patient with an autonomous hot nodule should have definitive radioiodine or surgical therapy on the assumption that the patient is destined to become hyperthyroid. In fact no case has yet been reported in which this has taken place, although undoubtedly it must have happened. But the usual thing is for variations in thyroxin output to occur, and sometimes there is a return to normal function.

In summary, then, I would say that my personal preference is not to employ any sort of active treatment in euthyroid patients with autonomous hot nodules because the ultimate outcome is excellent. No euthyroid patient has yet been reported to become toxic, and malignant conversion has not been seen. Exceptions to this "rule" would be in the patient with serious cancerophobia, in whom withholding surgery would not be to his advantage. Also, I think that if a nodule continues to enlarge or becomes very painful, or if other areas in the gland come under suspicion on palpation, one should consider surgery. But I think that one should not embark upon surgery in such cases without having performed TSH stimulation studies because in an occasional case there will be a nodule that is not autonomous but is compensating for the loss of functioning tissue elsewhere, and this cannot be detected by the simple scan without TSH stimulation. Patients who present with hyperthyroidism, or who become hyperthyroid secondary to an autonomous nodule, must of course receive appropriate therapy. This would usually be surgery or I^{131}.

Dr. Poland: Thank you, Doctor Mallin. Doctor Pohlmann, you appear to have a comment to make.

Dr. Pohlmann: I would like to make a point of some importance in connection with evaluation of these nodules, which is that the pattern of iodine uptake and thyroid hormone production differs in the nodular and the normal tissue. In the tissue of diffuse hyperthyroidism, Graves' disease, both uptake and hormone production are greatly accelerated and they may have passed their peak at 24 hours. This is true also for the hot nodule. Perhaps, therefore, if we were to study more of the patients with hot nodules at an earlier time—say at 8 or 12 hours—we might find that more of them presented the uptake and hormone levels, as well as the clinical evidences, of hyperthyroidism.

Dr. Donald M. Willson: It seems to me that the most important practical point brought out by Doctor Mallin is that these hot nodules have not been demonstrated to become toxic. One tends instinctively to think of an autonomous nodule—that is functioning on its own to produce hormone without TSH prompting—as a process likely to run wild and plunge the patient ultimately into a hyperthyroid state. The evidence that this does not occur is very reassuring, for it makes no difference to the patient's economy whether his thyroxin is derived from a normal gland under TSH control or from an autonomous nodule that is operating independently of TSH.

Dr. Glenn H. Franke: What of the nodule that has burned itself out and is now "cold?" If you had

not had the opportunity to see it becoming cold, what would be your attitude toward it?

Dr. Mallin: If the nodule were completely cold with good function around it in the remainder of the tissue, and if it were distinctly palpable and I was seeing it for the first time, I woud have no hesitancy in looking upon it as a cold nodule that should come out. It is certainly true that most cold nodules are benign; nevertheless a small proportion of them are carcinomatous, and therefore they should all come out in such instances as that you describe. However, in such a case as the one which I have illustrated with the series of scans, I think you might look forward to the ultimate development of a type of burned-out "cold" nodule that may be safely left in.

Dr. Pohlmann: I think our incidence of carcinoma in a cold nodule in this hospital is about 5%.

Dr. Willson: I doubt that this figure is a valid one because it is derived solely from cases that were surgically explored. Clinical carcinoma of the thyroid is a rare disease compared with the frequency of nontoxic nodular goiters.

Dr. Philip H. Seefeld (Chief, Department of Surgery): Upon the other hand, I think that the figure is actually a little higher than that. In my own reported series of 68 solitary nodules, 9% were carcinomatous. I recall that in an earlier time, before we had the I^{131} and scanning technics, we considered the patient with a hyperfunctioning solitary nodule as a surgical problem, and I think that he probably still is because these individuals do not respond as well or as completely to radioiodine or antithyroid drug therapy as they do to surgery. Many of the nodules that are being studied nowadays with the newer technics are in a sense "laboratory nodules" since they do not present with symptoms that require such immediate therapeutic decisions.

I would like to ask whether in the histological study of these solitary autonomous nodules they are always found to be encapsulated and loaded with colloid, or are they sometimes just aggregates of thyroid cells that are not confined to a certain area by encapsulation?

Dr. Pohlmann: In the Mayo Clinic series, there were a few trabecular and papillary patterns, but most of them were macro- and/or microfollicular.

Dr. Seefeld: But were they encapsulated?

Dr. Pohlmann: Yes.

Dr. Seefeld: Then with that kind of architecture it is difficult to conceive that they are going to disappear under any type of nonsurgical approach.

Dr. Mallin: The experience has been that with radioiodine therapy most of them become smaller but do not disappear. Under the circumstances that I have stated, I am not concerned with whether they disappear or not.

Dr. Poland (summarizing): I think it may be said that in the brief time at our disposal this morning we have presented adequately the problem of the "hot" thyroid nodule and had a good exposure to the rationale of its therapy, old and new. □

CIRCADIAN RHYTHM OF ADRENAL CORTICAL ACTIVITY IN DEPRESSION

FRANCIS N. LOHRENZ, MD, DONALD T. FULLERTON, MD, FREDERICK J. WENZEL, BS, JULIUS J. CHOSY, MD, and KENNETH B. DICKSON, MD, with technical assistance of LEONARD REINEKE, MT, ASCP, Marshfield Clinic, Marshfield, Wis: *Behavioral Neuropsychiatry,* July 1969

Adrenocortical activity in 21 depressed and 21 control patients evaluated by measuring three hour plasma cortisol (fluorimetric steroids) and urinary 17-hydroxycorticoids (17-OHCS) values showed the psychotically depressed patients to have an earlier nadir of plasma values, 1700, at 5 P.M. as compared to 2300 in neurotically depressed patients. Urinary 17-OHCS values did not correlate specifically with the plasma cortisol determinations. Statistics showed that the more severely depressed individual had more disturbance in circadian rhythm than those with a lesser depressive reaction. The expected early morning rise in adrenocortical activity was changed to much earlier in both plasma cortisol and urinary 17-OHCS values. This possibly correlates with the typically early morning insomnia present in severely depressed patients. Close correlation of plasma cortisol levels and urinary 17-OHCS excretion studies in both men and women in the controls in this study indicated that sex differences were not of significance. The observations of disturbance in timing and rhythm of the circadian rise and fall of adrenocortical activity in depressed patients was consistent with the hypothesis that the activation of the pituitary adrenal axis in depression depends on the amount of discomfort that the patient was experiencing. Of subsequent particular interest will be the measurement of the "free" portion of the plasma cortisol, which is not bound to corticosteroid binding globulin, or CBG. It is probable that the degree of symptoms of discomfort may be more clearly correlated with the unbound cortisol, rather than with the total plasma cortisol concentration measured by present methods. □

NEW RESEARCH . . .

U-3243: Shown to be effective against herpes simplex infection in animal studies. The drug also appeared to be safe and without serious side effects in oral tolerance tests in healthy prison inmates. The formula for this drug is 4′-[2-nitro-l-(p-tolylthio) ethyl] acetanilide. By Drs. Ervin Novak, Carl A. Schlagel, and George Elliott, Upjohn.—Reprinted from AMERICAN DRUGGIST, July 14, 1969 □

MEDICAL HISTORY FEATURE

WILLIAM BEAUMONT'S TRAVELS AND THE "CHOLERA CAMPAIGN" OF 1832

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Madison, Wisconsin

Associate Professor of Medicine University of Wisconsin Medical School

THE TIMES and travels of U. S. Army Surgeon William Beaumont, from his commission as Surgeon's Mate in December 1812 until his resignation in April 1853, provide fascinating insight to the development of the western frontier and the Blackhawk and 1812 Wars.

During these turbulent times and under adverse conditions, he was to accomplish in 1833 the famous publication of "Experiments and Observations on the Gastric Juice and the Physiology of Digestion."

Of great medical interest during this period was the first epidemic of Asiatic cholera in the United States and its extension to the frontier during the Blackhawk War of 1832. Beaumont, the thinking physician that he was, was concerned, although, as the research of this report reveals, was denied first-hand experience during the first epidemic.

Primary source material has been microfilms of the Washington University School of Medicine Beaumont Letters and microfilm reprints of letters selected from the document file of the office of the Adjutant General and Surgeon General, 1812–1842, collected for the late Dr. F. A. Coller, Ann Arbor, Michigan.

At the time Beaumont entered service in 1812 at Plattsburgh, New York, he was an experienced practitioner and had kept careful notes concerning some of his interesting cases. This ability and detail to personal records undoubtedly contributed to the importance of the record he leaves of the medicine of those times.

His recorded experience at camps and battles along the Lake Ontario and Niagara frontier gives some insight into a nature of inquiry and comparison (Fig 1).

"Ascertained the treatment of the Surgeon of the 11th Regt. in this camp in diseases now prevailing, which is to give from one to three Emits. and as many cathartics, in order to cleanse the prima viae and obviate the symptoms of a bilious diarrhea, and then give tonics. Behold the gasping, gasping mortals, how they die! From two to five in a day! Twenty-six in the course of two weeks out of four hundred. Can it be correct practice when, in the next

Fig. 1—Portrait of William Beaumont as an Army surgeon. (From frontispiece of "Life and Letters of Dr. William Beaumont" by Jesse S. Myer, M.D., 1939)

Fig. 2—A section of the United States map of 1838 (published by T. G. Bradford, Massachusetts) at the time of William Beaumont's travels into the Northwest Territory. Michigan became a state in 1836 and the Wisconsin Territory was formed. Iowa became a separate territory in 1838. Wisconsin was originally claimed as part of the colony of Massachusetts and then made a part of the Northwest Territory after the Revolutionary War. Shortly, it was made part of Indiana Territory and then the Michigan Territory in 1805. (From author's collection)

Presented at the January 1968 meeting of the William Snow Miller Medical History Seminar at the Middleton Memorial Library, University of Wisconsin Medical Center, Madison.

Reprint requests to: Donald R. Korst, M.D., 3504 Blackhawk Drive, Madison, Wis. 53705.

Fig. 3—Scenes along the Wisconsin River traveled by Beaumont and his family. The canoe route was a two-to-three-day journey from Fort Winnebago at Portage to Fort Crawford at Prairie du Chien. (From author's collection)

regiment, out of six hundred, in an exactly similar situation and laboring under the same diseases, not one has died in the same time under a diametrically opposite practice? No! Depletion by blood-letting and antimonial sudorifics and diaphoretics, and an entire disuse of all tonic medicines, is the proper plan of cure." (December 12, 1812—North of Plattsburgh.)

The travel of the times was conducive to a hardy and rugged constitution. Water routes west predominated in the trade of furs and the frontier forts were at important junctions of the rivers and lakes such as Detroit, Mackinac, Green Bay (Fort Howard), Portage (Fort Winnebago), and Prairie du Chien (Fort Crawford), all in the Michigan Territory (Fig 2).

Travel on Lake Erie and Lake Huron was improved by use of sailing and side paddle wheel vessels such as the Walk-in-the-Water (330 tons and 200 passengers) which Beaumont took to his first assignment in the West at Fort Mackinac.

His travels farther west on later assignments at Fort Howard and Fort Crawford were made by canoe. The large Montreal canoes (bateaux) that became the real freighters of the fur trade era were never replaced by sailing ships. Such a canoe 35 to 40 feet long could carry 5 tons of crew and freight and with 14 men could make 4 to 6 miles an hour in calm and 8 to 10 miles an hour with wind at the back.

It was said that good voyagers could make Portage to Prairie du Chien in two days downstream and three days upstream with a full load of bales of merchandise, tobacco, flour, bags of shot lead balls, kegs of sugar, gun powder, wine, along with cases of guns, kettles, and family property, so that the canoe was loaded to the gunnels (Fig 3).

Descriptions of travel along the river routes usually mention the plagues of flies, big and little, mosquitoes and gnats that swarmed as thickly as bees about the hive. It was curious to observe the herds under a scorching sun avoid the shade of trees where insects most abound and place themselves where they could feel the full effect of the powerful rays, thus exchanging a greater for a smaller evil. Creatures who manifest a shyness of each other press closely together in promiscuous assemblage, as if by close approximation they hoped to crowd out their enemies.

Cash money of the times was lean. Much of the correspondence of Beaumont to the Surgeon General's office concerns what one might consider trivial sums unless the buying power of a few cents in 1820 is appreciated. The army surgeons were allowed private practice at the western forts as they were often the only physicians.

A suggested fee schedule might have read: office visit 25 cents, riding per mile 20 cents, doctor in the night 38 cents, consultation $1, and an obstetrical case $3.50 (assuming the doctor could get it).

A story of the times told of the farmer's wife who needed a needle. The farmer, not having a penny, selected a large hen's egg and walked eight miles through the snow to the village store. It was the custom to furnish a drink of whiskey with each purchase. After receiving a new needle for the egg, the farmer said he supposed he was entitled to a drink. Certainly, said the merchant and drew a half tumbler. The farmer then requested an egg in the drink, so the merchant broke the egg he had just received, which contained a double yoke. The farmer, as he drank, allowed as how the egg was double yoked that he perhaps was entitled to two needles. The merchant thereupon gave him another needle, the men shook hands, and they parted.

Beaumont's travel time was not spent in idleness. As he sailed from Buffalo on the three-day trip to Detroit, his notebook reveals that he began to adopt the code of Benjamin Franklin (Fig 4) which lists 13 virtues in one column and the days of the week in the opposite column. Whenever these are broken, a black dot is entered so that a clear line throughout the week would indicate a virtue strengthened.

His virtue was also reflected in a letter from Mackinac Island to Surgeon General Lovell, former friend and associate in the 1812 War, in a request for furlough to marry in Plattsburgh. He wrote, ". . . but other potent reasons urge the request. To live a bachelor and alone on this

Form of the Pages

TEMPERANCE.							
Eat not to Dulness. Drink not to Elevation.							
	S	M	T	W	T	F	S
T							
S	••	•		•		•	
O	•	•	•		•	•	•
R			•			•	
F		•			•		
I			•				
S							
J							
M							
Cl.							
T							
Ch.							
H							

Fig. 4—An example of a page from Benjamin Franklin's notebook of a scheme for moral improvement. This was published in Franklin's autobiography in 1790, but perhaps not in complete form until 1818. Beaumont, May 31, 1820, while aboard the steamboat Walk-in-the-Water enroute from Buffalo to Detroit, studied the plan to attain moral perfection and on September 9 commented that he was starting his own diary of conduct. Franklin wrote, "Let sleep not close your eyes till you have thrice examined the transactions of the day; where have I strayed, what have I done, what have I omitted?" Each day the faults were noted as a black dot opposite the list of 13 virtues in the left column. The virtue to strengthen that week is stated at the top of the page, leaving the other virtues to their ordinary chance. One could complete 4 of the 13 week self improvements in a year's time, aiming for a record of increasing pages clean of black dots. The names of the virtues with their precepts were:

1. TEMPERANCE. *Eat not to Dulness. Drink not to Elevation.*

2. SILENCE. *Speak not but what may benefit others or yourself. Avoid trifling Conversation.*

3. ORDER. *Let all your Things have their Places. Let each Part of your Business have its Time.*

4. RESOLUTION. *Resolve to perform what you ought. Perform without fail what you resolve.*

5. FRUGALITY. *Make no Expence but to do good to others or yourself: i.e. Waste nothing.*

6. INDUSTRY. *Lose no Time. Be always employ'd in something useful. Cut off all unnecessary Actions.*

7. SINCERITY. *Use no hurtful Deceit. Think innocently and justly; and, if you speak, speak accordingly.*

8. JUSTICE. *Wrong none, by doing Injuries or omitting the Benefits that are your Duty.*

9. MODERATION. *Avoid Extreams. Forbear resenting Injuries so much as you think they deserve.*

10. CLEANLINESS. *Tolerate no Uncleanness in Body, Cloaths or Habitation.*

11. TRANQUILITY. *Be not disturbed at Trifles, or at Accidents common or unavoidable.*

12. CHASTITY. *Rarely use Venery but for Health or Offspring; Never to Dulness, Weakness, or the Injury of your own or another's Peace or Reputation.*

13. HUMILITY. *Imitate Jesus and Socrates.*

(From FRANKLIN: Autobiography; Yale University Press, 1964)

Efforts Underway for Beaumont Commemorative Stamp

FIVE YEARS AGO an historically-minded Wisconsin physician suggested that efforts be made to secure a commemorative postage stamp honoring Dr. William Beaumont.

The State Medical Society of Wisconsin, through its Charitable, Educational and Scientific Foundation, started the wheels in motion. In May 1967 the House of Delegates passed a resolution promoting issuance of the stamp in 1972.

The resolution follows:

WHEREAS, It was while stationed at Fort Crawford, now Museum of Medical Progress and Stovall Hall of Health, in Prairie du Chien, Wisconsin, that Dr. William Beaumont, a military surgeon, completed his pioneering experiments in the physiology of digestion which form the basis of our present day knowledge of the digestive process; and

WHEREAS, More than one state claims the honor of his fame, including Connecticut, where he was born; Vermont, where he was first licensed; Michigan, where he first examined his patient, Alexis St. Martin in 1822; and Missouri, where he was buried, therefore be it

Resolved, That the State Medical Society of Wisconsin petition the Postmaster General of the United States to issue a commemorative postage stamp honoring Doctor Beaumont on the 150th Anniversary (1822–1972); and be it further

Resolved, That other interested states be asked to join in a campaign for issuance of a Beaumont commemorative stamp in the year 1972.

Subsequent to the passage of this resolution, the Michigan State Medical Society's House of Delegates passed a similar resolution, and the medical societies of Missouri and Connecticut endorsed the Wisconsin resolution.

The Wisconsin Legislature passed a resolution recognizing Doctor Beaumont's contributions to medical science and calling for the United States Postmaster General to issue a commemorative stamp in 1972.

The Michigan Legislature, too, has passed a similar resolution endorsing a commemorative stamp issuance.

A representative of the Postmaster General has acknowledged the efforts being made in behalf of the issuance, stating that the proposal will be considered in 1971 at the time the stamp program for 1972 is formulated.

To commemorate William Beaumont in this manner would focus attention on one of medicine's great achievements and create much pride among the medical community.

The State Medical Society of Wisconsin was instrumental in the issuance of a traffic safety stamp and a Workmen's Compensation stamp, both in 1961. It is the hope of the Society that the Beaumont stamp will be issued in 1972. Further support will be sought and efforts intensified next year.

desert, isolated isle, I am not contented; to mingle with its copper colored inhabitants I cannot; to marry I am resolved; to Plattsburgh I must go (if permission be obtained) for there my direction is needed."

The gunshot wound to Alexis St. Martin that created the "famous fistula" occurred in 1822 and first reports to the Surgeon General were made in 1824.

Recognition was prompt and Beaumont was offered the first honorary membership in the Medical Society of the Michigan Territory in March, 1825.

The first series of experiments were made at Mackinac, Fort Niagara, and Plattsburgh, requiring Beaumont's sponsorship of the French-Canadian voyager at these various stations.

In 1828 Beaumont moved his family and St. Martin and family to Green Bay and then to Prairie du Chien.

In order to appreciate the true sense of the wilderness in this part of Wisconsin in 1828, a short narrative of one of the first white settlers is of interest. One of the earliest comers to the southwestern part was Ebenezer Brigham of Blue Mounds. He journeyed from Massachusetts to St. Louis in 1818, thence, in the the spring of 1828, he removed to Blue Mounds, the most advanced outpost in the mines. The nearest settler was at what is now Dodgeville, about 20 miles distant. Mineral Point and most of the other diggings, where villages have since grown up, had not then been discovered. On the southeast, the nearest house was on the O'Plain River, twelve miles west of Chicago. On the east, Solomon Juneau was his nearest neighbor, at the mouth of the Milwaukee River; and on the northeast, Green Bay was the nearest settlement—Fort Winnebago not then being projected.

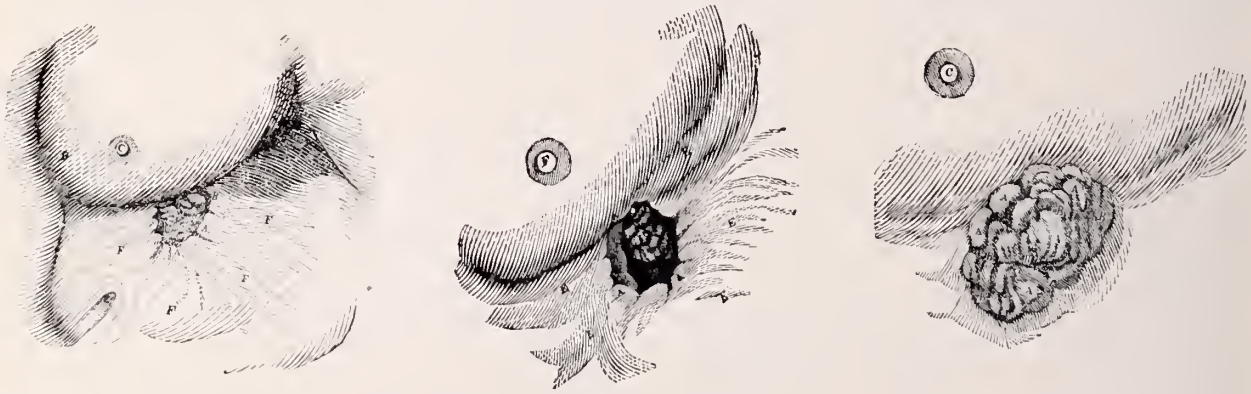
It was at Fort Crawford, Prairie du Chien, that the second series (Fig 5) of gastric physiology experiments were carried out from June, 1829, costing Beaumont $160 annually to support the St. Martins. In addition, he outfitted Alexis, his wife and three children to return by canoe to Montreal in April 1832, via St. Louis, the Ohio River, and Lake Erie, with arrival home in June just in the middle of the first cholera epidemic on the North American continent. St. Martin is noted to have withstood the ravages and impurity while hundreds around him fell sacrifice to its fatal influence, although it is not documented that he actually had the disease.

Undoubtedly Surgeon Beaumont had many contacts with the Indians, although he writes little of them (Figs 6 and 7). He pleads with Congress to grant better benefits and furlough for those who have the long and arduous duty (12 to 14 years) on an extreme frontier.

It is probable that he remained in the hospital of the old fort while the main garrison moved to the new Fort Crawford; at least in May 1831, he made a report of a survey of medicines destroyed by collapsed shelves due to rotting wood.

Beaumont was busy writing to arrange a scientific furlough in order to carry out further studies and complete his book in the East. He was frustrated during this time by the development of the Indian uprising and the outbreak of cholera. As it turned

Fig. 5—Three views of the "famous fistula" of Alexis St. Martin as depicted by Beaumont in his original manuscript.



A

This engraving represents the ordinary appearance of the left breast and the side, the aperture filled with the valve; the subject in an erect position.

(AAA) The circumference and edge of the aperture, within which is seen the valve.

(B) The attachment of the valvular portion of the stomach to the superior part of the aperture.

(C) The nipple.

(D) The anterior portion of the breast.

(E) The scar where the opening was made with the scalpel, and the cartilages taken out.

(FFFF) Cicatrice of the original wound, around the aperture.

B

This engraving represents the appearance of the aperture with the valve depressed.

(AAA) Edges of the aperture through the integuments and intercostals, on the inside and around which is the union of the lacerated edges of the perforated coats of the stomach with the intercostals and skin.

(B) The cavity of the stomach, when the valve is depressed.

(C) Valve, depressed within the cavity of the stomach.

(EEEE) Cicatrice of the original wound.

(F) The nipple.

C

This engraving represents a portion of the stomach prolapsed through the aperture, with the inner surface inverted, and spread out over the integuments of the side.

(AAAAA) Folds or rugae of the inner coats of the stomach.

(BBBB) Interstices, filled with mucous substance.

(C) The nipple.

(Figs. 5A, B, C from Original Manuscript and Life and Letters of William Beaumont by MYER; William S. Middleton Memorial Medical Library, University of Wisconsin, Madison)

out, neither of these reached Fort Crawford prior to August 22, 1832, when leave was granted to Beaumont by Col. Zachary Taylor.

The war was short, lasting from spring until the final action at the Bad Axe River, August 2, 1832. The correspondence and notebook entries are sparse during this period. It appears that Surgeon Beaumont was mainly concerned with continuing his important experiments and that there was never an immediate concern at Fort Crawford of the war or epidemic.

Blackhawk, an elder in the Sac tribe (Fig 8), led his people, including wives and children, east across the Mississippi to reoccupy former lands. The presence of women suggests motives other than a war party; indeed, there were few battles in this war, the major actions being when the troops caught up with the fleeing Indians.

The great fear of Indian uprising along the frontier prompted President Jackson to order his senior general, Winfield Scott, to move troops from the East to support the existing regular troops under General Henry Atkinson. It was the movement of these troops that probably caused 95% of the morbidity in the war and introduced cholera to the frontier.

During 1831 the cholera was epidemic in Europe, and by June 15, 1832, there was an outbreak in Quebec among 40,000 recent immigrants. Then, via upper New York state, the first case in New York City was reported on June 26. As the epidemic began there was a mass exodus of those who could afford to travel and the peak was reached about July 20.

The great fear of cholera was enhanced by its sudden onset; as one New York physician said, "The first symptoms appear with little or no warning. I felt no premonition of cholera at all until I pitched forward in the street as if knocked down with an axe." This was truly the first collective social disaster shared by all the people of the new nation alike.

The following extract of a private letter from a veteran officer of the army who was on board the "Henry Clay," besides giving an interesting description of the outbreak, pays a high tribute to the fidelity and efficiency of Assistant Surgeon Kerr:

"In 1832 the troops in New York Harbor and elsewhere were ordered to the west to act against the Sac and Foxes then hostile to us. Accordingly the Fourth Artillery embarked on the eighteenth of June for Chicago, via the Hudson River, the canal and lakes. The Asiatic cholera had then just made its appearance in Canada, but not yet in the United States, and all along the line of the canal to Buffalo we met evidence of panic and alarm among the citizens.

Fig. 6—Sauk and Fox Indians, typical of the Indians along the Wisconsin River. (From The American Heritage Book of Indians, pp 206–210, Ed. JOSEPHY, A. M., American Heritage Publishing Co., Inc., 1961)

Fig. 7—A scene at Prairie du Chien in August 1825, drawn by J. O. Lewis as part of an Aboriginal Port-Folio in the Library of Congress. A grand council with the Chippewa, Sauk and Foxes, Menominee, Iowa, Sioux, Winnebago, Ottawa, and Potawatomi was held with government representatives to define the boundaries of their respective land claims. (From The American Heritage Book of Indians, pp 206–210, Ed. JOSEPHY, A. M., American Heritage Publishing Co., Inc., 1961)

Fig. 8—A still-proud Black Hawk (right) and his son were painted by John Jarvis in 1833 when they visited the East as prisoners of war. (From The American Heritage Book of Indians, pp 206–210, Ed. JOSEPHY, A. M., American Heritage Publishing Co., Inc., 1961)

Fort Crawford and Military Hospital in 1829

Fig. 9—Fort Crawford and the Hospital at the time of Beaumont's continued experiments on Alexis St. Martin and the interruption due to the Black Hawk War or "Cholera Campaign." From a painting in the Museum of Medical Progress at Prairie du Chien, Wisconsin. (Reproduced through courtesy of State Medical Society of Wisconsin, photo by Gordon Peckham, Museum curator)

"We arrived without incident at Buffalo and sailed from thence on the third of July on the steamer Henry Clay, Assistant Surgeon Robert E. Kerr, a young officer, being our only medical officer, and of him and not of our expedition I propose to write.

"On the afternoon of the Fourth of July, after we had a Fourth of July dinner, being off the port of Erie, and while the young officers were joking about the cholera, the then prominent subject of thought, the hospital steward came into the cabin and reported to the doctor that one of the privates was taken suddenly very ill.

"We went on deck and found the man in great agony, and the doctor at once pronounced it a case of cholera. He took the case in hand and was unremitting in his attentions, but the man died at half past three the next morning. This was, I think, the first case in the United States, and the man came immediately from Baltimore and had never been where the cholera was.

"Before he died another case occurred, and during the night we arrived at Detroit, where we were visited by Dr. Everett and several citizen physicians who all pronounced the disease to be Asiatic cholera.

"General Scott ordered us to proceed about three miles up the strait, and there await his further orders. The next morning, having been joined by Dr. Everett, who was chief of General Scott's Medical Staff, we were ordered to proceed on our voyage.

"The cases at this time increased very fast, the first three being from Major Payne's company, but then it extended not only to the other troops but also to the crew, so that before we got to Fort Gratiot (Port Huron) the decks were covered with the dead and dying, and not enough men remained to navigate the vessel, so that the voyage was broken up and we landed about a mile below Fort Gratiot where we encamped.

"A heavy rain came on and the cases increased rapidly and among them Dr. Everett, so that Dr. Kerr was the only medical officer. The sick were removed to a neighboring barn, which was soon filled; I counted one morning in passing it, six dead bodies lying outside awaiting burial.

"The disease raged with unabated fury (including several officers among its victims, of which two, Dr. Everett and Lieutenant Clay died) until July 11th, when it began to abate though there were daily deaths for some time afterwards. Amid all these scenes, Dr. Kerr, unassisted, attended to officers and men both day and night, and I think never had the slightest relaxation during that time. His devotion to duty was the admiration, and his power of endurance the wonder of all.

"The last case was taken sick on the sixteenth, and the last death occurred on the twenty-first. We lost, I think, between forty and fifty, and I lost one-third of my company."

Stern measures were shortly in force as the cholera epidemic became a far greater threat to the army than the small band of Sac Indians hiding in the forest of northern Illinois. At a public meeting in Detroit, a sum of $1,000 was raised to protect the village by barring all persons from Canada, inspection of all ships one-half mile down stream, and prevention of eating unripe cherries, apples and pears; and by publishing a daily cholera bulletin, "The Cholera Beacon."

Settlements along the Chicago road had armed guards, fences across roads, and no trespassing allowed to the point that the stage coach to Ann Arbor was turned back by the local colonel of militia. At Mackinac, General Scott went among the troops and noted that intemperance invariably led to the plague, so ordered that "any man found intoxicated should dig a grave his own size and contemplate it with understanding that if he persisted in drinking he would soon fill it himself."

Scott moved his troops, already more than half depleted, to Chicago. He wisely decided to isolate his troops and ordered General Atkinson in Wisconsin to pursue the Blackhawk tribe, thereby preventing spread to Fort Crawford and the Mississippi. He wrote, "I am fully aware of the heavy responsibility that rests upon one for the spread of a dreadful malady among the troops under my orders and through them prematurely among the population of this immense valley. I have never regarded myself as having been born to be a curse to my country."

The local scene in Chicago at the time was described in the travel journal of a young man—Chicago at that time 50 people, 5 buildings, and Fort Dearborn. "The 14th of July was a day never to be forgotten. The night before a schooner landed at this place and brought word that the troops would be here in a day or two at most and this was hailed as an event that would terminate the war speedily . . . word was brought to us that the steamboat Shelden Thompson had landed and brought the cholera. Fifteen had been thrown overboard after sundown. General Scott . . . was sick in the bakehouse next door and was not expected to live until morning. All was confusion. The troops were

ordered out of the fort for the reception of sick soldiers and with frightened soldiers calling to each other, dogs barking, Indians hallooing rendered it an awful scene.

". . . I shall always remember the scene. The prairie on one side with enemies on it at probably no great distance. The other, Lake Michigan, on it the dark steamboat, like a dark putrid mass for so it appeared according to the stories reported." Scott's isolation of the upper Mississippi forts was successful and the epidemic did not reach the area until later in 1832, probably by way of Cincinnati, St. Louis, and New Orleans.

It is little wonder that the fear associated with cholera so impressed the physicians and particularly Beaumont. The records of the war and Fort Crawford (Fig 9) do not indicate the presence of cholera in Prairie du Chien at the time of Surgeon Beaumont's tenure, and the first cases reported from Galena were to occur after he left on furlough to Washington, D. C.

Much speculation as to the cause of the disease appears in the literature of the 1830s, and one member of the New York Board of Health Special Council proposed a reward of $20 for any licensed physician who cured a case of cholera.

The filth and habits of the times were generally held to contribute to the spread of the disease. A New England physician remarked that not one in five of his patients bathed or washed their bodies in water once a year. A New York health official reported that street cleaning in the city was left to thousands of swine that roamed the streets plus goats and dogs and, facetiously, that the city water was far better than any other, since it served as a purgative as well as for washing and cooking.

In one poll of 109 physicians, 90 thought the disease not at all contagious; 14 that it was noncontagious except under certain conditions; and 5 thought it contagious due to some substance of "Terrene" origin in the atmosphere, the latter thinking being the "miasmatists."

Apparently there was a complete lack of sanitation in most frontier communities, prompting the populace to flee to the countryside during epidemics. Other traditions of the era played their part in spread of the plague, such as the custom of sopping, whereby in public houses and road taverns a central pot of meat and gravy was dipped into with chunks of bread by the guests seated about the table.

Beaumont recognized the importance of cleanliness at Fort Crawford when he reported, "The healthfulness and efficiency of the troops at this post are unprecedented within the limits of my recollections, and I cannot consistently with my own belief and in justice to the disposition and efforts of the commanding officer of the post (Major Kearny) forbear to observe the present extraordinary state of health and good condition of the troops."

A scribbled piece of paper, probably from Beaumont's notebook and probably written during this period, reads, "The greater proportional number of deaths in the cholera epidemic are, in my opinion, caused more by fright and presentiment of death than from the fatal tendency or violence of the disease. Like a snake, watching and mouthing its prey, the *cholera* lurks unseen through the pestiferous pens and malarious atmospheres, stealing upon human beings and thickly populated places and gluts its cadaverous appetite more by the fear and dread it occasions than by its otherwise naturally fatal efforts upon human life."

During the next epidemic of 1849, Beaumont, retired and living in St. Louis, was to write specific therapeutic suggestions which included friction to increase circulation, opium, calomel, cupping, bleeding, and, but lastly . . . alkaline drinks.

The free use of alkaline drinks is very useful in all stages of the disease. However, he expressed the futility of many physicians attempting to slow the epidemics when he wrote, "Relatives and friends shrink with sorrowful emotions, and doctors stand aghast in mute astonishment and mortification at the relentless rapidity of a disease so little understood and over which their most profound skill and judgment and professional efforts can have no salutary influence or effect—a disease which I conceive to be sui generis of atmospheric origin, sent by God over the face of the earth to scourge mankind."

How close and yet so far were many physicians during the early epidemics of cholera. The accepted treatment always contained calomel in some plan with bed rest, tea, and bleeding in the late stages. Daniel Drake advised these plus advice to go to bed and send for your family physician—terror is a great exciting cause of the disease and requires treatment.

He described the blood in cholera as black, pitchy and coagulates loosely, is deficient in serum, and often has the same qualities in arteries and capillaries as the veins. The calomel and opium were usually mixed with brandy and taken generously three or four times daily or given straight in a "thumping" dose. The epitome of this was the Calomel Poem:

The man in death begins to groane
The fatal job for him is done
His soule is wing'd for heaven or hell
A sacrifice to Calomel
And when I must resign my breath
Pray let me die a natural death
And bid you all a long farewell
Without one dose of Calomel

Therapy in general was poor. Sir Thomas Watson, a great English physician, said, "If the balance could be fairly struck, and the exact truth ascertained, I question whether we should find the aggregate mortality from cholera, in this country, was any way disturbed by our craft."

Several remarkable discussions about the deficiency of salts in cholera blood and the use of intravenous saline were written by Stevens of London, 1832; Brigham of Hartford, Connecticut, 1832; and Joslin of New York, 1835. They emphasize the severe dehydration and need of fluids but underestimate the true need of fluids by many liters. Two tablespoons of salt in 6 ounces of warm water given by mouth is noted to cause emesis but improvement in some.

One moribund patient treated in New York by the injection into the vein of a salt solution was observed; the circulation was restored, the temperature increased, and cold perspiration converted to an animating warmth. Of 226 cases treated by the saline treatment in London, there were 200 recoveries, which was considered an improvement from an expected 50% mortality.

A Mr. Smart of Cranborne (1831) is given credit for devising the operation of intravenous injection.

Many great physicians, including Beaumont, during the first epidemics of cholera apparently were thinking of saline replacement, but none were quite able to comprehend the actual

tremendous salt depletion of cholera. Had a person like Beaumont had more exposure to cases and the time to study and observe free from the confusion and fears of the epidemic, he might have made another great contribution.

The concepts that enabled John Snow to later construct a meaningful theory of cholera causation, the statistics that helped him in validating his ideas, the public health organization that could put this knowledge to use, did not exist in 1832.

William Beaumont, the Blackhawk War, and the 1832 cholera epidemic were intimately intermeshed in the Michigan Territory (Fig 10). Surgeon Beaumont perhaps just missed a second place in medical history for important observations on the cause and treatment of cholera. The Blackhawk War took second place to the cholera epidemic and cost the government $2,000,000.

The Sac tribe ceded the eastern fifth of what is now the state of Iowa in trade for $20,000 for 30 years; a blacksmith shop; 40 kegs of tobacco; and 40 kegs of salt. Chief Blackhawk was imprisoned shortly but gained a grand tour of eastern cities, including an audience with the president. The cholera claimed the lives of 250 settlers and about 100 regular army troops in the northwest.

And lastly, the Michigan Territory was surveyed after the war with the final report: "The amount of tillable land in two million acres is less than 1/100 of the area. This land of bogs, lakes and swamps is not worth the expense of further surveying."

Fig. 10—The Wisconsin map of 1841 shows the marked increase of new settlements in the new territory. Madison was designated the capital in 1837 by the territorial legislature. The population of 31,000 was mainly along the Wisconsin River route and the Dodgeville–Mineral Point lead-mining region. [*Published by Carey and Hart, Philadelphia.*] (From author's collection)

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3. Clements Library, University of Michigan, Ann Arbor, Michigan.
4. Medical Library of Washington University School of Medicine, St. Louis, Missouri.
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ARE YOU INTERESTED IN MEDICAL HISTORY?

The Academy of Medical History (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

PRESIDENT'S PAGE

ROBERT E. CALLAN, M. D.

AULD LANG SYNE

As we enter the 1970s, it is quite the rage and perhaps the expected to join the crowd in shining up the crystal ball to glibly or profoundly catalogue the tremendous changes in the delivery of medical services that will occur in the next few years, changes that were unthinkable only a few years ago. Some of these current accounts of oncoming attractions or distractions (depending on how your particular bias operates, of course) carry the tainted evangelism of a side-show barker, while some more somber predictions suggest a degree of infallibility not even accepted in matters of faith and morals these days.

Very few propheteers indeed are reluctant to add to the confusion or to the great semantic tidal wave that inundates and dulls objective consideration. Nearly all predictions are heavily opinionated and not a few come from instant experts whose ready tongue and pen summarize the viewpoints of others with which they are in accord. Everyone is getting into the act, and instead of the plot—how to deliver quality medical care to all at a reasonable cost—thickening, it is apparently becoming simpler and more naive.

The patient—the consumer in today's parlance—really is a member of the silent majority, although he has just about every "expert" claiming to speak for him. As a sop to a maligned medical profession, staggering under a politically-induced demand for services it is temporarily unable to meet, nearly all of the soothsayers offer the same hollow promise that the private sector of medicine, by doing the impossible in the next few months, may still stave off government control.

Although I hesitate to prophesy events to come in the 70s, it seems likely that politics and finance will be the two greatest determinants of the direction and rate of change in the delivery of health services. Change is always with us and is necessary for progress in our society; it is the greatly accelerated rate of change that is being argued, and rightly so, for history amply documents that we live with our mistakes and rarely retrace our steps.

National health insurance—color it universal, voluntary, or compulsory—seems to be just around the corner. What this could do to the present health-insurance industry hardly needs explaining. We can only hope that the management knowledge of this private sector will be preserved to give some hope of sound operation, not readily found in the bureaucratic process.

The great "Thirty Year War for Prepaid Closed Panel Group Practice" appears to be reaching a climax with the heavy artillery of government money and propaganda emplaced while "Fee-for-Service" and "Free Choice of Physician" are digging in desperately. The salaried physician, followed by price and wage controls, appears to be the ultimate objective in this conflict.

There also is ferment for change within our own profession as well as pressures from without. The American Medical Association, at its clinical session in Denver Nov. 30–Dec. 3, discussed the most important report to come before its House of Delegates in recent times. The Report of the Committee on Planning and Development covers 60 pages in the Delegates' Handbook and recommends changes in the philosophy, policy, responsibility, scope of activity and commitment of the AMA.

This committee report was received by our delegation two weeks before the Denver meeting, precluding a proper study and dissemination of its contents. In view of the great importance of the report to every member of our Society, our Council—meeting in Madison Nov. 22—went on record as supporting the AMA Board of Trustees' recommendation that this report be received for information only and that there be no specific action on its contents at the Denver meeting. On Dec. 2 in Denver the AMA House directed that a special committee be formed to study the document and report its findings and recommendations to the House at the AMA Annual Meeting in June 1970 in Chicago. The House also requested that the entire report be transmitted to the component state societies for such specific action as their governing bodies deem warranted.

Everyone seems to agree that after years of talking about it, the AMA must now—without delay—proceed with short and long-range planning and development efforts to keep our organization relevant and effective. Let's get on with it!

And a happy and prosperous New Year . . .

Robert E. Callan M.D.

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Gifts That Keep Giving

How much more significant and valuable are gifts that pay honor and result in lasting benefit to society. Such gifts truly honor the person in whose name they are made, and they speak eloquently of the high-minded purpose of the donor.

The problem of what to give the man who has everything is often a vexing one. Most professional people come through the holidays loaded down with meaningless merchandise that does no one any good except those who sold it. Many people feel that the only way to pay respect, to honor or to express high regard is to transmit a material token. The resulting grotesque waste of money is one of the scandals of contemporary life.

A contribution to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin can be used as a means to pay tribute to the memory of a respected friend, colleague or relative. Or it can be used to honor the living on the occasion of birthdays, anniversaries, or other happy events. Whatever the occasion, an appropriate acknowledgment is sent to the person honored without divulging the amount of the gift. And the donor receives a receipt for the contribution to assist him in claiming a tax deduction.

When the occasion has passed, the donor has the satisfaction of knowing that his gift has not been discarded or relegated to gathering dust on a shelf of forgotten, unneeded merchandise. For a contribution to the CES Foundation is used to promote professional medical education and research, for public health education, to assist physicians who become needy, to lend money to medical students, and for many other philanthropic purposes. The benefit of the gift endures indefinitely—and is shared by the entire community.

The next time you wonder what to give as a gift, think of the Charitable, Educational and Scientific Foundation. By contributing, you will be getting—and giving—greatest value for your gift dollar.

—D.N.G.

National Recognition

All those who know Dr. G. S. Custer will share with the medical fraternity of Wisconsin, as we do, the satisfaction that comes with his elevation to the office of president-elect of the American Association of Medical Clinics.

Dr. Custer—"Stan" to his associates—has amply demonstrated his qualifications for this national honor and will be a credit to the organization he will head in 1971. During his quarter century of experience in the medical field here, he has built an enviable reputation.

A conscientious practitioner of the healing arts, he has been everything a patient could expect a doctor to be, and in addition to keeping up with the astounding developments that have marked the progress of medical science during those years, he has found time for community service outside the bounds of his own profession.

As a member of the local library board and as president of the Palm Sunday Music Festival for many years, he has shown his interest in the cultural aspects of the Marshfield scene, while his service as president of the Marshfield Clinic and as a member of the National Advisory Health Council attest to his expertise in the field of group medical practice.

With this background Dr. Custer was a logical choice for the office to which his colleagues have elected him. We know that he will serve them well and we take a certain smug satisfaction in the realization that his selection and his future performance will reflect favorably on what is probably the smallest city in the nation to have so large a medical clinic.—Reprinted from the Marshfield News–Herald, Sept. 25, 1969 □

COUNCIL MINUTES

MADISON, AUGUST 2–3, 1969

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 2:00 p.m., Saturday, August 2, 1969, at the State Medical Society.

Voting members present: Doctors Schrank, Galgano, Nordby, Davenport, Smejkal, Dettmann, Boren, Manz, Doyle, Egan, Wright, Past President James, and President Callan. Present Saturday only: Doctors Huth, Mauthe, Sullivan, Foley, Houghton, and Speaker Behnke.

Others present: President-elect McRoberts, Vice-speaker Nereim, AMA Delegate Picard; Alternates Kief and Carlson present Saturday only; Doctors Nellen and Chosy present for special orders Saturday.

Staff and consultants: Messrs. Crownhart, Thayer, Koenig, Brower, Reynolds, McIntyre, LaBissoniere, Murphy, Gill; Mrs. Anderson and Miss Pyre. Present Saturday: Messrs. Maroney, Tiffany, Kluwin.

2. Special Order

James W. Nellen, M.D., President of the Board of Regents of the University of Wisconsin, spoke to the Council on matters of current interest in medical education.

Following this discussion, on motion of Doctors Houghton–Boren, the Council requested that the Commission on Hospital Relations and Medical Education discuss with the University of Wisconsin Medical School admissions committee the current drop-out rate and applicant interview policy.

3. Approval of Minutes

On motion of Doctors Houghton–Sullivan, carried, minutes of the May 11 and 14, 1969, meeting were approved.

4. Oath of Office

The oath of office was administered by Chairman Nordby to Councilors Schrank, Galgano, Davenport, and Doyle; AMA Delegate Picard, Alternate Delegates Kief and Carlson.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

5. Status Report on WPS Charge Card Corporation

Mr. Kluwin discussed the July 3 letter from the office of the Insurance Commissioner, which had been circulated to the Council, and the substance of the Society's reply again stating the purpose of the experimental program and seeking another conference in the hopes of avoiding litigation. This produced agreement to a meeting on August 4, but Doctor Nordby pointed out that if differences were not resolved, action had been taken July 24 and earlier authorizing litigation to clarify the authority of WPS as a division of the Society to invest in conducting such an experiment.

6. Report of Council Committee on Scientific Medicine

Doctor Houghton reported the following recommendations, with Council action indicated:

A. Speakers Service and Postgraduate Teaching Programs

On motion of Doctors Houghton–Foley, carried, the Council approved the recommendation that the CES Foundation continue to accept funds from Merck Sharp & Dohme for support of these programs.

B. Annual Meeting Exhibits

(1) Bio–Med Laboratories, Inc., Milwaukee; United Medical Laboratories, Inc., Portland, Oregon

On the question of providing exhibit space to the so-called commercial laboratories, the committee recommended that the Council adopt a mechanism for establishing criteria and standards to be applied in considering applications for exhibit space.

Following discussion, and on motion of Doctors Houghton–Behnke, carried, the Council stated that any laboratory that meets the requirements of Medicare may be accepted for exhibit.

(2) Imperial Fashions of Los Angeles, California

On motion of Doctors Houghton–Foley, carried, the Council approved the recommendation not to accept any future request from this custom-made clothing firm for exhibit space.

(3) Programmed Learning, Inc., Garden City, New York

On motion of Doctors Houghton–Mauthe, carried, the Council authorized continuation of this exhibit.

C. Calibration and Standardization of Biomedical Instruments

The committee was informed of a study being undertaken at the University of Wisconsin Instrumentation Systems Center, and of its desire for information from physicians concerning instrumentation problems.

The committee recommended that a group of qualified physicians be asked to prepare an appropriate questionnaire to be directed to physicians particularly concerned.

There was general agreement with the chair that before any steps are taken, contact should be made with the AMA on what may have been developed elsewhere.

D. Guidelines for Nurses in Coronary Care Units

On motion of Doctors Houghton–Foley, carried, the Council accepted the committee's action approving "Guidelines for the Role of the Registered Professional Nurse in the Care of Patients with Cardiovascular Disease in the Coronary Care Unit" which had also been approved by the Commission on Hospital Relations and Medical Education.

E. Annual Meeting Financing

The Commission on Scientific Medicine had again in June recommended that commercial exhibits be eliminated from the 1971 Annual Meeting to be headquartered at the Pfister Hotel.

On motion of Doctors Houghton–James, carried, the Council approved the committee recommendation to uphold the decision of May, affirmed by the House of Delegates, that the present method be continued through 1974.

7. Commission on Health and Natural Resources

L. W. Chosy, M.D., member of the Commission, discussed the recent meeting with the State Health Officer and Sanitary Engineer, on the subject of safe swimming waters. As indicated in the minutes which the Council received, no agreement could be reached on what might constitute "safe" swimming waters, or what criteria might be used for better determining such safety. The Commission concluded to ask the physicians of the state to provide documentation of health problems believed to be connected with swimming waters, since public health officials contend there is no evidence of disease transmission through bathing waters.

Doctor Egan suggested that this matter also be reported to the Commission on State Departments.

8. Report of Executive Committee

Minutes of the June 28 meeting had been forwarded to the Council and were summarized by Doctor Callan. They were largely informational, but Council action was taken on the following recommendations:

A. Hilliard Fellowship Fund

On motion of Doctors Sullivan–Houghton, carried, the Council approved a $3,000 appropriation from the Society general fund to the CES Foundation to initiate the fellowship, with the possibility of its repayment should the fund be substantial enough in the future.

B. Conference on Aging

On motion of Doctors Behnke–Foley, carried, the Council approved in principle Society sponsorship of a Conference on Aging as recommended by President Callan, and requested it be presented with a fiscal note for further action.

Doctor Callan reported also on the July 31 meeting of the Executive Committee with that of the Wisconsin Hospital Association at which there was an exchange of information on the subjects of hospital emergency services, the shortage of physicians especially for rural areas, licensing of foreign physicians, smoking and health, educational programs to be conducted in hospitals, physicians on governing boards of hospitals, the WPS Charge Card Corporation, and the Marquette financial problem.

There were no recommendations requiring action by the Council at this time.

9. July AMA Meeting Report

Doctors Kief, Picard and Carlson reported on various actions taken, which have been summarized in the AMERICAN MEDICAL NEWS and are not repeated here. Doctors McRoberts and Callan also gave their impressions of the meeting.

10. Report of Finance Committee

Doctor Dettmann reported to the Council in executive session and according to notes furnished the Secretary, this covered the committee's review of Annual Meeting finances, the midyear status of the general fund operating expense budget, and costs of publishing the Workmen's Compensation panels due in 1970. The following recommendations were made and accepted by the Council:

A. Luncheons for graduating seniors at both medical schools —exercise some control on attendance by issuing invitation to the graduate and his immediate family, and request a response.

B. Establish a more realistic contingency fund in future operating budgets.

C. Reemphasize to committees and commissions and their chairmen the need for fiscal notes.

D. Explore possibility of financial support from insurance carriers in publishing and distributing the Workmen's Compensation panels.

E. Urge President Callan to consider ways to improve attendance and reduce the loss on the Annual Banquet.

The Council recessed for dinner and reconvened for a slide presentation by Mr. Thayer on the organization of the Society and its affiliates, during which time the Executive Committee continued its noon meeting.

The Council reconvened at 9:30 a.m. on Sunday, August 3.

11. Community Service Award

The Council had previously authorized solicitation of nominees for a Community Service Award made available annually by A. H. Robins for a physician selected for civic and community contributions providing an outstanding example of service above and beyond the scientific. It is intended that the recipient be honored at the Society during the Work Week of Health.

On motion of Doctors Schrank–Doyle, carried, the Council approved the nomination of two physicians from the same city in anticipation that this will be acceptable to the company.

12. Report by W. D. James, M.D., Immediate Past President

Doctor James reported his experience of attending the Apollo 11 launch upon invitation from NASA.

He also presented the award to WHA–TV and Wisconsin Physicians Service for the television series, "Youth on a Four-Day Trip," taped during the 1968 Work Week of Health. This was from the American Legion Auxiliary, Department of Wisconsin.

13. Medicare and Medicaid

Mr. McIntyre gave an informational report on the recently announced eleven-point program of HEW Secretary Finch. relating applicable parts to the Society's present administration of the programs in Wisconsin, and likely future impact as in the matter of government enforcement of payment limitations, which have not presented a real problem here to date.

14. Further Report of Executive Committee

Doctor Callan reported on the August 2 meeting of the committee:

A. Physician Nominations

The committee reported its nomination of members for appointment to the USP Committee of Revision; State Advisory Radiation Protection Council; Citizens Advisory Committee on Program Standards, Department of Health and Social Services.

B. Marquette School of Medicine Financial Crisis

On motion of Doctors Egan–Galgano, carried, the Council adopted the following resolution as recommended by the committee:

"Recognizing that the Marquette School of Medicine has played an essential role in educating physicians and other personnel and that the need to expand medical services is more vital than ever to the health of Wisconsin residents today, which facts are thoroughly documented according to the Governor's Task Force on Medical Education; and

"Recognizing that the State Medical Society of Wisconsin has in the past evidenced its support for the continuance of the Marquette School of Medicine; and

"Recognizing the critical financial situation of the Marquette School of Medicine which if not immediately relieved may lead to the school's closing;

"Be it resolved:

"1. That the Councilors and Officers of the State Medical Society today express their recognition that the closing of the Marquette School of Medicine would have calamitous consequences for the health of Wisconsin residents, and

"2. That the State Medical Society use its energies, resources, and talents to solicit and secure help from all segments—public and private—in Wisconsin and anywhere else to keep the Marquette School of Medicine operating and to enable it to expand its program in line with the Governor's Task Force recommendations."

On motion of Doctors Egan–Boren, carried, the Council also authorized the filing of a brief amicus curiae if legal counsel determine this to be advisable.

Staff will be guided by the President, President-elect, and Chairman of the Council on such further steps as the Society might take to supplement the advertisements and other dissemination of information. Mr. Crownhart pointed out that total financial commitments could exceed $20,000 and would necessitate some cutbacks in other activities.

C. Uniform Anatomical Gift Act

On motion of Doctor Galgano, seconded and carried, the Council approved the recommendation that the Society take the lead in developing appropriate forms for implementation, and submit them to other interested parties.

D. 1970 Summer Council Meeting

On motion of Doctor Boren, seconded and carried, the Council approved the recommendation of the committee that the Council meet in northern Wisconsin next summer.

E. Cream City Medical Society

Doctor Callan discussed informationally his suggestion to the county society of a neighborhood health center in Milwaukee, and from this came a recommendation that the Executive Committee establish liaison with the Cream City Medical Society.

F. Wisconsin Blue Shield

The Council had received copy of a letter from Mr. Kelley concerning WPS advertising. This has been referred to the Commission on Medical Care Plans, but the Executive Committee reported its consensus that this should not become a major issue and should await word from National Blue Shield.

15. SMS Realty Corporation

Doctor Nordby reported on a July 30 meeting of the board of trustees with the architects on existing space problems and what use could best be made of Society property to unify office operations. The board was not prepared to submit final plans and recommendations, but present thinking is to construct a three-floor addition of 20,000 square feet each adjacent to the existing building, but as a self-contained unit. The board is continuing negotiations under prior authorization for purchase of the remaining property between the Society and the socalled Easter Seal site.

16. Adjournment

The meeting was adjourned at 11:30 a.m.

C. H. Crownhart
Secretary

Approved:
E. J. Nordby, M.D.
Chairman

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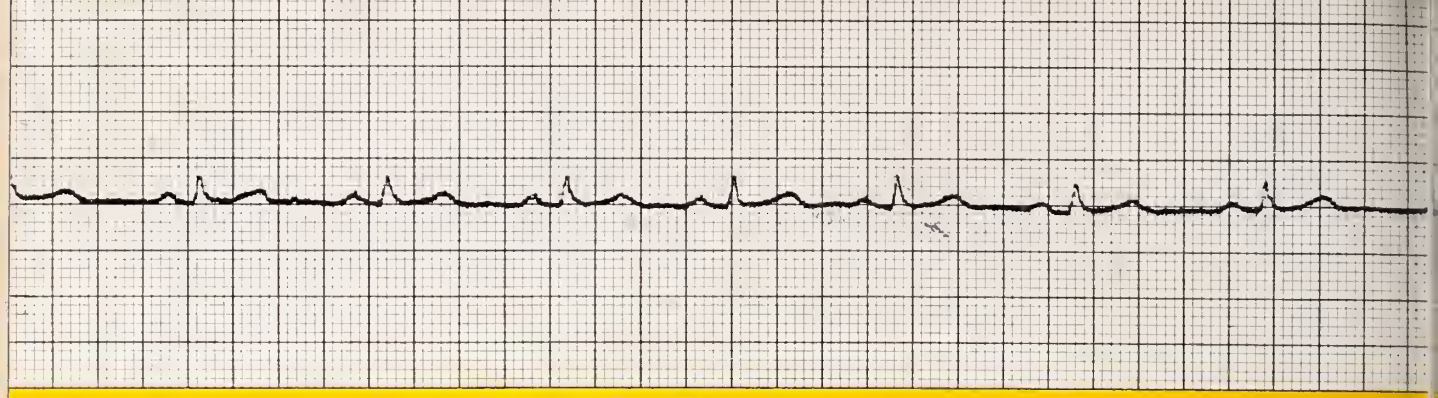

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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